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Tasmanian Government Submission to the Inquiry into Acute Health Services in Tasmania

Legislative Council Sessional Committee
Government Administration Committee A
Sub-Committee
Acute Health Services
in Tasmania

Tasmanian Government

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September 2017

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1 Introduction

Structure of this Submission

The Tasmanian Government welcomes the opportunity to make this submission to the Legislative Council Inquiry into Acute Health Services in Tasmania (the Inquiry).

Despite significant improvements in recent years, Tasmania's health system continues to face a number of challenges which have been persistent and entrenched over a substantial period of time. These have been the subject of numerous reviews and reports, including:

- The Tasmanian Hospital System: Reforms for the 21st Century, 2004 (the Richardson Report);
- Tasmania's Health Plan, 2007;
- Legislative Council Inquiry into the Cost Reduction Strategies of the Department of Health and Human Services, August 2012; and
- The Commission on Delivery of Health Services in Tasmania (the Commission): Working towards a sustainable *health system for Tasmania*, April 2014.

It is not the intention of this submission to reproduce the evidence and findings contained in those reports. However, attention is drawn to the 2014 report of the Commission, which helped to inform the health reform process currently being undertaken by the Government. The report can be found at:

https://stors.tas.gov.au/store/exlibris3/storage/2014/05/09/file_3/1240287.pdf

The central theme of this submission is that, in the absence of a significant change in health policy, system architecture and consumer expectations, demand for acute health services will increase at a rate which will, in the long term, affect the sustainability of the health system. It is for this reason that the Government has embarked on a system wide program of health reform. However, clearly it takes time for the benefits of that reform to be fully realised. In the meantime, the Government is ensuring that the immediate healthcare needs of Tasmanians are being met through a range of measures to address short term demand issues.

The remainder of this section outlines key reforms currently being undertaken by the Government. Subsequent sections then respond to each of the Terms of Reference in turn. A separate section is dedicated to mental health.

The Need for Reform

The impetus behind the Government's comprehensive reform of the health system was a need to address the findings of past reviews (within the context of the current and proposed system architecture) and position the system to achieve the Government's vision of Tasmania having the healthiest population in Australia by 2025.

There were a number of factors that have built momentum towards implementing meaningful, long-lasting and effective transformation of the health system. As well as the failure to realise the intention of previous reform attempts, drivers included the failure to appropriately implement the reforms under national health reform; financial pressures; governance and management failures and findings; and the need to improve the focus on patient care.

While this Inquiry is restricted to the acute health system (as defined in Appendix 1), it should be noted the Tasmanian Government has been undertaking a significant and continued examination of the entire health and hospital system and recognises that reforms are required to all parts of the system.

Current Tasmanian Government Health Reforms

One State, One Health System, Better Outcomes

Through the *One State, One Health System, Better Outcomes* (One Health System) reforms, the Tasmanian Government is implementing a complete overhaul of Tasmania's health system. The *White Paper on Safe and Sustainable Clinical Services* (the White Paper), released on 28 June 2015, outlines how the Government is reforming the Tasmanian health system to deliver better health services and realise the Government's vision for Tasmania. The White Paper can be accessed at www.onehealthsystem.tas.gov.au.

The One Health System reforms are guided by the overarching principles of "putting patients first" and "access to better services". The reforms are aimed at delivering a more sustainable, more accessible and more engaged health system that serves the Tasmanian community.

The reforms recognise Tasmania is best served by having a single health system with facilities and people networked to achieve high quality, safe and efficient services where the patient journey is tracked from community to hospital and back to community again. The first phase of acute system reform was to define the capacity and capabilities of our health facilities to provide safe and sustainable clinical services of defined complexity. This was achieved through the development of a Tasmanian Role Delineation Framework, which informed the mapping of services to develop a valid Tasmanian Clinical Services Profile.

This process identified how to best configure services to provide better outcomes for patients, by ensuring:

- high quality health services that are only delivered where appropriate support services are available;
- access to better quality care (as opposed to simply better access to care without consideration of its quality and sustainability); and
- more efficient services with less duplication, freeing up resources to provide more services that the community needs and did not have access to.

Under the One Health System reforms, people will get the care that they need at the hospital that is best able to provide it. This means more day-to-day services being delivered locally, but high complexity services consolidated into our larger hospitals.

Where a service is not available locally, systems and process will be put in place to:

- provide transport and accommodation assistance to facilitate access to services;
- provide low-cost accommodation for families where a longer stay in hospital is required; and
- where appropriate, bring the service to the patient e.g. utilising telehealth.

To support this, the Government has committed $24 million towards improving arrangements for the transport, accommodation and coordination of care for patients across the hospital system (known as the Patient Transport, Care Coordination and Accommodation Project). This investment addresses some long-standing service gaps in patient transport and assists Tasmanians to access the services they need.

Statewide Clinical Service Delivery Structure

In recognition of the entire patient journey, the Tasmanian Health Service (THS) continues to work with the community, doctors, nurses, allied health professionals and other key stakeholders to build a better health service for all Tasmanians.

The *Building a Statewide Clinical Service Delivery Structure* project will deliver foundational change for the THS which will enable it to progressively meet the objectives of ongoing health care reforms to provide Tasmanians with access to better health care. As a single health system under the THS, every clinical discipline has a statewide focus.

The THS is building the foundations for the necessary clinical leadership to support the delivery of health care services to all Tasmanians with local clinical and nursing directors. The THS is also working to better integrate primary and community care, including health and parenting services nurses. Importantly, these services will continue to work side by side and in partnership with the acute care facilities to improve end-to-end care provision across our health system.

Primary and Community Health – Tasmanian Government Reforms

The heavy focus of the White Paper on the four major acute hospitals and subsequent reforms is a reflection of the persistent issues that Tasmania has faced in the delivery of acute hospital services. However, as stated in the White Paper, the focus on acute services does not discount the role and importance of other parts of the health system, including primary and preventative health.

The Tasmanian Government recognises that an efficient and well-functioning hospital can only exist in conjunction with appropriate ambulatory, preventative and primary and community health services.

The Government has developed bold strategies to reform our health system from end to end.

Healthy Tasmania Five Year Strategic Plan

Under the Healthy Tasmania Five Year Strategic Plan[1] (Healthy Tasmania), we are delivering initiatives to reduce smoking, encourage healthy eating and physical activity, develop community connections and manage chronic health conditions. Effectively targeting these risk factors is likely to yield the greatest population health benefit which, in turn, will reduce the stresses on our health system.

Rethink Mental Health

The Rethink Mental Health Plan[2] (the Rethink Plan) delivered on the Government's commitment to develop an integrated Tasmanian mental health system that provides support in the right place, at the right time and with clear signposts about where and how to get help. The Rethink Plan establishes a 10 year vision that brings together action to strengthen mental health promotion, prevention and early intervention; action to improve care and support for people with mental illness, their families and carers; and sets a path for integrating Tasmania's mental health system.

As part of the broader mental health reform in Tasmania, set out in the Rethink Plan, the Government released the Tasmanian Suicide Prevention Strategy, which includes a specific Youth Suicide Prevention Plan and a Workforce Development and Training Plan. The strategy documents outline a renewed focus and commitment to suicide prevention and aim to reduce suicide, suicidal behaviour and impacts in Tasmania. They recognise the specific knowledge, services and resources that exist in Tasmania and were developed to align with the health system and broader reform under the Rethink Plan.

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1 Tasmanian Government Department of Health and Human Service, 2016, Healthy Tasmania, Five year Strategic Plan, www.dhhs.tas.gov.au/__data/assets/pdf_file/0008/224567/Healthy_Tasmania_Strategic_Plan_Web_v8_LR.pdf

2 Tasmanian Government Department of Health and Human Services, 2015, Rethink Mental Health, Better Mental Health and Wellbeing: A long-term plan for mental health in Tasmania 2015-2025 www.dhhs.tas.gov.au/mentalhealth/rethink_mental_health_project

Ambulatory

In April 2016, the Tasmanian Government released *Patients First*, a range of actions focused on ensuring that patients receive more timely care in emergency departments (EDs) at the Royal Hobart Hospital and the Launceston General Hospital. The Review of Ambulance Tasmania Clinical and Operational Service (the AT Review) was subsequently undertaken by the Department of Health and Human Services (DHHS), delivering on the Patients Firsts commitment to "*examine enhancing the scope of practice for paramedics to enable them to manage pre-hospital and potential ED demand including reviewing the potential for secondary triage and referral to alternative services*"

The final report on the AT Review, released on 6 June 2017, identifies reforms to increase the efficiency on Ambulance Tasmania resources and to reduce demand on emergency services.[3] The Tasmanian Government has already taken action on the Review with the announcement of funding for two new ambulance crews (one each in Greater Hobart and Launceston) in the 2017-18 State Budget (the Review is discussed further in Section 2).

Primary and Community Health – Joint State-Federal Initiatives

To manage and reduce demand for acute services, it is important that the primary and community health system is developed and fully utilised where appropriate to safely manage illness in the community. The State retains a strong interest in the aged care and disability reform agendas as the State shares the same client base and the systems are interdependent in creating good patient outcomes. The State's role lies in supporting the development of low-cost high-impact services that foster resilience. This resilience enables people to remain at home and/or be discharged from hospital as soon as they are able.

Given primary care is largely the responsibility of the Australian Government, it is essential that both levels of government work together in this critical area of reform. To this end, in 2016, the Council of Australian Governments (COAG) signed a Heads of Agreement which committed to developing reforms to improve Australians' health outcomes and decrease avoidable demand for public hospital services through better coordinated care, particularly for patients with complex and chronic disease. This commitment will be given effect through a bilateral agreement between the Tasmanian and Australian governments, which is currently under negotiation. The bilateral agreement will promote joint planning between the DHHS, the THS and Primary Health Tasmania (PHT); facilitate the sharing of data and information; and enable opportunities for collaboration between DHHS, the THS and the Australian Government's Health Care Homes (HCH) reform.

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[3] Tasmanian Government Department of Health and Human Services, Review of Ambulance Tasmanian Clinical and Operational Service, Final Report 2017, www.dhhs.tas.gov.au/about_the_department/our_plans_and_strategies/at_review

The Tasmanian Government is also committed to supporting people with chronic conditions to manage their condition at home and in their community by identifying and trialling new models of anticipatory care – a key action in Healthy Tasmania.

PHT is a key partner in the implementation of these reforms. DHHS, the THS and PHT are committed to working together and have entered into a *Memorandum of Understanding for Working Together to Improve the Health of Tasmanians* (the MoU).

Reforms pursued under the bilateral agreement, Healthy Tasmania and the MoU will complement other Tasmanian Government reforms, such as the Community Rapid Response Service (ComRRS) which is providing quality care in the community for people with chronic and complex illnesses and help to keep them out of hospital. ComRRS is a project of the One Health System reforms, supported by $3 million over three years in Tasmanian Government funding. An interim evaluation has shown that ComRRS is achieving its goal of providing a cost effective, responsive, high intensity intermediate service for people in the community with either an acute illness/injury, or acute exacerbation of a pre-existing chronic/complex condition, that would otherwise require ED attendance and/or period of hospitalisation. In addition, home and community care services are being developed to better target health outcomes that will help people to retain resilience and access acute care because it is needed, rather than because of a failure of self-care.

Revised National Health Reform Agreement

The Heads of Agreement signed by COAG on 1 April 2016 included a commitment to develop and implement reforms to improve Australians' health outcomes and decrease avoidable demand for hospital services by:

- better coordinated care, particularly for patients with complex and chronic conditions;
- funding and pricing for safety and quality;
- reducing avoidable readmissions to hospital; and
- the Australian Government focussing on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions.

The Heads of Agreement has led to a time-limited addendum to the National Health Reform Agreement. The addendum amends certain elements of the NHRA for the period 1 July 2017 to 30 June 2020.

The Heads of Agreement notes that the addendum to the NHRA is in anticipation a longer-term public hospital funding agreement to commence from 1 July 2020. This longer-term agreement is to be developed by all jurisdictions and to be considered by COAG before September 2018. The Tasmanian Government will work with the Australian Government and other Australian states and territories to develop this agreement, which is expected to address many of the issues being examined by this Inquiry.

2 Term of Reference 1 - Current and projected demand

Forecasting Acute Services Demand

As part of its role as system manager, DHHS considers likely future demand for patient care in its forward planning processes. The factors traditionally regarded as the best predictors of future activity are:

- historical trends in activity;
- changes in population (including changes in age structure); and
- changes in the technologies and treatments available across the health system.

However, more recently, demand for acute services has been increasing at a faster rate than these factors would suggest. For example, in some locations demand continues to increase despite a stable, and in some cases declining, population. Nor does population ageing fully explain the increased demand, although DHHS acknowledges that the ageing of "baby boomers" will – due to the sheer size of this population cohort – impact on health care demand over the coming decade. It is likely that increased demand for acute services is due to a range of other factors, including:

- increased demand for services from patients with multiple morbidities;
- the public responding to promotion and social marketing that constantly reinforces the availability of free high-quality health care;
- availability or accessibility of General Practitioner services in some areas and/or a lack of General Practitioner services outside regular business hours;
- local and structural challenges in establishing or scaling up home and community-based services able to provide more intensive levels of medical, nursing and rehabilitation support to patients, which can avoid admission to hospital; and
- the increasing out-of-pocket cost of primary care, resulting in demand shifting to the acute sector.

There is strong evidence that a strategy to manage entry into acute care is through the implementation of strong primary and community care sectors, and establishing and maintaining effective the pathways between these services and the acute sector.

Based on historical trends and likely demographic changes, DHHS estimates that demand for admitted and non-admitted services will grow at around three per cent per annum over coming years. This pattern of constant linear growth in demand for acute services is the same as that seen nationally. While the Tasmanian Government will continue to invest in the health system to meet this rising demand, slowing the rate of demand growth is vital to enabling the health system to remain sustainable in the long term and to improve the welfare of Tasmanians. This requires both primary prevention of disease (via the Tasmanian Government's *Healthy Tasmania* Five Year Strategic Plan), and robust secondary prevention and management of chronic conditions. As noted, a key challenge will be to manage more of this growing demand in community and home-based settings, and to develop more effective and cost-effective methods of caring for patients with multiple morbidities that span the current boundaries of the primary, community and acute care sectors.

Recent trends in hospital activity

Admitted Patients

The Tasmanian Government's investment in public hospitals over the past three years has been reflected in the increased activity as measured by total separations[4], non-admitted service events and admissions for elective surgery (Appendix 3: Table 1).The total separations in all Tasmanian public hospitals increased between 2013-14 and 2015-16 from 114 033 to 122 604, an increase of 7.5 per cent. Over this period, overnight separations increased by 9.6 per cent (from 53 974 to 59 167) and same day separations by 5.6 per cent (from 60 059 to 63 437)[5].

Between 2013-14 and 2015-16, the number of overnight admitted patients in Tasmania has increased at a greater rate than for same-day patients (Appendix 3: Table 2). This is in contrast to the national trend, whereby same-day separations have increased faster than overnight admissions (Appendix 3: Table 3). In 2015-16, the share of same day separations in Tasmania was slightly lower (51.7 per cent of total separations) than nationally (52.6 per cent).

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[4] A separation in relation to patient care, is defined as "an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care" (AIHW, 2017).

[5] AIHW, 2017, Admitted patient care 2015-16: Australian hospital statistics.
AIHW, 2016, Admitted patient care 2014-15: Australian hospital statistics.
AIHW, 2015, Admitted patient care 2013-14: Australian hospital statistics.

In 2015-16, Tasmania had a lower rate of public hospital separations (both overnight and same day) than the Australian average rate of separations per 1000 population (see Appendix 3: Table 3). However, the relative stay index for case-mix adjusted separations shows that Tasmanian public hospital activity was more complex, with a rate of 1.02, compared to 0.97 nationally.

Elective Surgery

The number of admissions from the elective surgery waiting list in Tasmanian public hospitals increased between 2011-12 and 2015-16 from 15 802 to 18 973[6], an increase of 20.1 per cent over this period (see Appendix 3 - Table 4). The largest increase over this period occurred in 2015-16, with the number of admissions increasing from 15 598 in 2014-15 to 18 973 in 2015-16 (AIHW, 2017). This increase in elective surgery activity reflects the Tasmanian Government's significant investment of resources into this area.

During 2015-16, removals from the elective surgery waiting list significantly exceeded additions to the waiting list, with 19 224 additions and 21 730 removals for that year. This enabled the achievement of substantial progress in reducing excessive waiting times for surgery (see Appendix 3: Table 5). Removals from the elective surgery waiting list mainly consist of those patients who have received elective surgery, with a smaller portion of removals being for other reasons.

As shown in Appendix 3 Table 5, additions to the elective surgery waiting list remained in a relatively stable range in the years preceding 2015-16. In that year, additions to the waiting list rose noticeably, following substantial increases in the volume of admissions that year. This is consistent with national and international evidence which suggests that additions ("demand") for elective surgery rise in response to increases in supply, rather than supply responding to pre-existing demand. There is little reason to believe that underlying changes in disease status in the population at large would drive such a rapid increase in "demand" for elective surgery – rather it represents changing behaviour by health services in anticipation of greater operating capacity remaining available in future.

Recent DHHS data shows that in 2016-17 the number of patients who were admitted for surgery from the elective surgery waiting list has continued this trend upward, with 19 929 statewide admissions from the elective surgery waiting list occurring between April 2016 and March 2017.

[6] Actual total admissions in 2015-16 were over 19 000, but AIHW data have not yet been updated to reflect this activity.

EDs - presentations

Emergency presentations include attendances for an actual or suspected condition that is sufficiently serious to require acute unscheduled care.

Presentations at Tasmania's public hospital EDs have grown steadily over recent years. Between 2011-12 and 2015-16, ED presentations rose from 141 700 to 153 541, an average increase of two per cent per annum over this period (see Appendix 3: Table 6). These presentations are not distributed uniformly throughout the year, with demand peaking at certain times such as "flu season".

While growth in ED presentations has risen at around two per cent per annum, the increase in admissions to hospital has grown at a faster rate, indicating that patients of higher morbidity are presenting to ED.

EDs - wait times

In 2015-16, Tasmanian public hospitals had a longer ED median waiting time[7] of 27 minutes compared to 19 minutes nationally, a higher 90th percentile waiting time of 120 minutes compared to 93 minutes nationally, and a lower proportion of presentations seen on time at 66 per cent compared to 74 per cent nationally (see Appendix 3: Table 7).

More information on EDs can be found in the supplementary paper on Emergency Care that was developed as a support paper for the One Health System reform Green Paper[8].

Non-admitted Patients

Non-admitted patient care provided in public hospitals includes care provided in outpatient clinics. Care provided at outpatient clinics includes consultation with specialist medical practitioners, diagnostic or other procedures, or allied health or specialist nursing care.

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[7] Emergency department waiting time is the time elapsed in minutes for each patient from presentation in the emergency department to the commencement of the emergency department non-admitted clinical care. The proportion of emergency department patients seen on time takes into account the urgency category with 'on time' being a different time period in each category (*resuscitation* - immediate; *emergency* - within 10 minutes; *urgent* -within 30 minutes, *semi-urgent* -within 60 minutes; *non-urgent* -within 120 minutes).

[8] http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/179056/OHS-OP04-Emergency_Care_vF_141208.pdf)

The total number of non-admitted patient service events in public hospitals increased between 2011-12 and 2015-16 from 349 000 to 521 322, an increase of 47.4 per cent over the period (see Appendix 3: Table 8). However, it should be noted that this increase is partly due to an increase in the scope of recording of non-admitted patients, as more categories of non-admitted activity have come to be covered by Activity Based Funding (ABF) in recent years. The Tasmanian trend for non-admitted patient service events closely mirrors that seen nationally.

Public hospital beds

The number of public hospital beds in Tasmania increased between 2011-12 to 2015-16 from 1 188 to 1 314, an increase of 10.6 per cent.

Tasmania's rate of beds available per 1 000 population has increased from 2.32 beds per 1 000 population in 2011-12 to 2.54 in 2015-16. This increase has brought Tasmania's rate closer to the national rate of 2.56 beds per 1 000 population in 2015-16 (Appendix 3: Table 9).

In the 2017-18 State Budget, the Tasmanian Government announced funding for more than 100 new hospital beds across the State. The Government has established a New Beds Implementation Team to enable these beds to be opened as soon as possible.

As discussed further in Section 3, capacity for 250 new beds is planned as part of the Royal Hobart Hospital (RHH) Redevelopment which is due to be completed in mid-2019.

Importance of Primary and Community Care

In considering the current and future demand for acute health services, it is important to recognise that acute care is part of a continuum of care that spans across a broad range of health services, including ambulatory, primary and community health services. Acute health services cannot operate effectively in isolation. Effective integration of care between home, community and hospital has long been recognised as a prerequisite for effective and sustainable acute hospital care and is a vital component of the Tasmanian Government's *One Health System* reforms.

A continued and increased focus on primary health services and integration across the continuum of care is needed to address the major challenges being faced by health care systems in Australia. The essential role of primary health in the overall health system is recognised in the World Health Report 2003 which states that "a health system based on primary health care will organise integrated and seamless care, linking prevention, acute care and chronic care across all components of the health system"[9]. Other evidence suggests that a strong primary healthcare sector is linked to improved population health, decreased health costs and improved health outcomes[10].

Despite the potential benefit to the health system of improved integration, the current national health funding arrangements (discussed further in Section 4) are focused on acute activity rather than outcomes and do not fund (or reward) demand management via the use of lower-cost primary and community care.

Ambulance Tasmania

Reforming the service model and capabilities of Ambulance Tasmania can contribute to better patient care by supporting pathways to care for patients outside of EDs.

Over the past seven years, the utilisation of ambulance services has grown 14 times faster than Tasmania's population. Left unchecked, this growth will have significant implications for Ambulance Tasmania's ongoing resource requirements and/or for ambulance response times. Unconstrained growth will also continue to have a negative impact on public EDs; which are already facing significant demand pressures.

Ambulance Tasmania's service model is well suited to responding to the needs of patients that require emergency care, stabilisation and transport to an ED. Increasingly; however, the caseload for Ambulance Tasmania involves responding to unexpected primary health care needs of patients. These patients may need urgent care, but unless their condition is life-threatening, they do not require the acute capabilities of an ED.

The best outcome for patients and the health system is to deliver efficient services that meet the need of patients. Often this means transporting a patient to an ED, but increasingly, the best option is found either through treatment at home or by primary or community health services. In some areas of Tasmania, over 40 per cent of all transported patients are categorised as non-acute. Statewide, only two per cent of patients are categorised as acute and time-critical once assessed by a paramedic.

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[9] World Health Organisation (2003) The World Health Report 2003, Chapter Seven -Health Systems: principled integrated care. http://www.who.int/whr/2003/en/whr03_en.pdf

[10] Starfield B Shi L & Macinko J (2005) *Contribution of primary care to health systems and health*. The Millbank Quarterly 83(3):457–502. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/

The percentage of ED patients arriving by ambulance is growing and is now higher than the national rate. An analysis of Ambulance Tasmania data from 2014-16 identified that 14.5 per cent of patients transported to EDs had a diagnosis able to be managed by either a paramedic, a community nurse and/or a general practitioner. Similarly, an analysis of ED data from 2014-16 show that 18 per cent of presentations brought in by ambulance were 'potentially avoidable'.

The Review of Ambulance Tasmania Clinical and Operational Services (the AT Review) identified a range of short term reforms to increase efficiency and reduce demand on emergency services. These included establishing secondary triage services, partnering with primary health services to manage or refer non-acute patients, expanding the current model for Extended Care Paramedics (ECPs) and monitoring new initiatives in other states.

Recent advice from Ambulance Victoria is that the introduction of secondary triage and their associated Clinical Response Model has reduced attendances to hospital EDs by approximately 11 600 people per annum. Of the calls that were found to be non-emergencies during the recent evaluation of the model, 40 per cent could be safely treated at home, 50.1 per cent could self-present at a doctor or hospital and 2.5 per cent were connected to a telehealth provider.

Developing formal referral and patient management partnerships between Ambulance Tasmania and primary and community health services will provide pathways to better assist non-acute patients. Tasmania's healthdirect is one such service, which has a working relationship with over 85 per cent of Tasmanian GPs and undertakes phone-based triaging and support. These health services may also be able to develop patient management plans for frequent users of ambulance services.

Ambulance Tasmania can also expand the role of ECPs in delivering emergency response services. These paramedics can be deployed to provide out-of-hospital intervention, such as wound care, catheterisation, and medication such as antibiotics or pain relief, in order to reduce ambulance delivery into hospital ED. DHHS will need to consider models for training of ECPs and clearly define their role compared to Intensive Care Paramedics in order to direct resources to appropriate patients and ensure assistance for those in acute need.

There are a range of other emergency service initiatives that Tasmania will monitor and could use in the future. Urgent Care Centres have recently been introduced in Western Australia to address the growing need for non-acute emergency care. Tasmania will continue to monitor the impact of Urgent Care Centres on demand for ED services.

The AT Review also recommended that Ambulance Arrivals Boards are introduced into EDs and Hospital Patient Tracking Boards into Ambulance dispatch to increase information flow and planning capacity.

Re-profiling the service model of Ambulance Tasmania to include both acute and primary care pathways will deliver better outcomes for patients and lower response times for those requiring critical care. While this alone is not a solution to current pressures on EDs, it will have a positive impact on demand for Ambulance and ED services.

The Government has implemented a number of initiatives to improve access to ambulance services. Under the Patient Transport Addendum to the White Paper, the Government committed to an extension of emergency ambulance services in the Latrobe/Devonport area by employing an additional 12 paramedics. A total of $5.4 million in recurrent funding over four years was committed to this initiative. The additional paramedics were employed from 27 June 2016, providing an additional two extra crews per day at times of peak demand.

The Government also committed to the further development of ECP programs. Funding of $1.4 million over four years has been provided for employment of three ECPs and acquisition of a First Intervention Vehicle (FIV) in Launceston. The program commenced with the delivery of a customised training program to the three successful candidates in August 2016. In the South, three ECPs have been employed as additional staff with greater scope of practice. These paramedics are experienced professionals with advanced training and additional skills in patient assessment and delivery of medical care. The additional skills allow these paramedics to ease pressure on our hospitals and allow the patients to be treated in their home.

Changes in the technologies and treatments available across the health system

The introduction of new technologies and treatments can be drivers of demand. Their introduction must be balanced by an assessment of their place within, and effect on, the current and future suite of services delivered within the hospital system. In addition, there is an increasing evidence base that challenges the efficacy of particular services currently being delivered and highlights unwarranted variation in practice within the hospital system (both nationally and in Tasmania) which must be taken into account also.

Nationally and internationally a number of models have been explored seeking to prioritise services through identification and restriction of superseded, ineffective, or low clinical value services. However, there are a number of political, clinical and social challenges to changing established practice. As the evidence becomes more definitive and the approach is better defined, Tasmania will need to consider ways to engage with clinicians to integrate changes to practice. This may be through incentives, pricing and funding for safety and quality, and investment in research to improve the evidence base.

The Commonwealth Department of Health has legislative, policy and program frameworks for reviewing unnecessary health care intervention, as well as, processes for reviewing new and emerging health technology. There are a range of advisory mechanisms that have representation from Tasmanian DHHS and Tasmanian Health Service that allows Tasmanian to contribute to national policy and incorporate this into local practice. For example the Medicare Benefits Scheme (MBS) Taskforce reviewed potentially ineffective services for possible removal from the MBS. Tasmanian data and clinicians helped inform these considerations.

An example of how Tasmania worked with national data to improve local practice can be seen in the work undertaken to reduce unwarranted variation in anti-anxiety and depression medication prescriptions. Primary Health Tasmania, together with the Tasmanian Health Service and the Department of Health and Human Services established initiatives to improve the quality of clinical care in mental health services and reduce the need for medication.

3 Term of Reference 2 – Factors impacting on the capacity of each hospital to meet the current and projected demand in the provision of acute health services

Ability of Hospitals to Meet Demand

Tasmanian health infrastructure has increased substantially over the past ten years and will continue to increase as the RHH redevelopment is completed and further investment is made across the State.

Previous studies into the Tasmanian health system have shown that Tasmania appears to have adequate acute health service capacity. Therefore it is important that focus is given not just to total capacity but also to how it is used – in particular where care could be more efficiently and effectively delivered with the patient at home and seen in primary, community or outpatient settings, or via telehealth. This section outlines the facilities provided at each of the State's four major hospitals and reasons why at peak period they may experience capacity issues.

Current Acute Hospital Infrastructure

Health infrastructure planning

The THS currently has Strategic Asset Management Plans for health facilities throughout the State. Most of these were developed under the previous Tasmanian Health Organisation regional model prior to implementing the *One Health System* reforms. The Plans focus on infrastructure requirements to operate facilities as they currently stand and include some consideration of future service need.

Royal Hobart Hospital (RHH)

Redeveloping the Royal Hobart Hospital is an integral part of the Tasmanian Government's strategy to meet the health care needs of all Tasmanians. The ageing condition and configuration of the buildings made it increasingly difficult to provide contemporary health services at the site.

The redevelopment of the RHH currently underway sees $689 million allocated by the Tasmanian and Australian Governments to construct a new inpatient precinct known as K-Block, consisting of two ten storey towers located on the site of the old B-Block. B-Block has been demolished and the services within it have been re-located to various locations throughout the RHH, including the Temporary Inpatient Facility constructed on Levels 2 and 3 of J-Block. The projected completion date for construction of K-Block is mid-2019.

The Government acknowledges that redeveloping an active working hospital necessarily involves some disruption to existing services. Thorough planning and risk management practices are ensuring that potential negative impacts on the RHH's operations are minimised.

On completion, K-Block will significantly increase the capacity of the RHH:

- 250 new overnight, on-campus beds are planned. This will increase the total bed capacity in the RHH by 67 per cent, from 371 to 621 beds;
- seven additional operating and procedure rooms are planned, increasing the total number from 16 to 23;
- consistent with contemporary health service delivery models, K-Block will provide improved patient care and operating efficiencies resulting from bringing together services in 'precinct' areas such as: women's adolescents and children's services; mental health services; medical services; and surgical services; and
- new models of clinical care have been developed with clinicians to reflect contemporary service attributes, and improve the pathways for patients from, and back to, community settings.

Launceston General Hospital (LGH)

The LGH was constructed in 1980 with the aid of Commonwealth funding for regional areas. Since that time there has been a continuing expansion and consolidation of health services in the immediate precinct, which includes the Allambie, John L Grove, Anne O'Byrne and Viewpoint facilities.

In recent years, substantial investment has been undertaken in refurbishing and expanding the LGH to accommodate growing demand for health services. This has included the expansion of the ED, the construction of an Acute Medical Day Procedures Unit, a Short Stay Surgical Unit, the expansion of the Intensive Care Unit and surgical wards, the refurbishment and extension of the Specialist Clinics and redevelopment of the Allied Health Clinics. In addition, nine surgical theatres have been built or upgraded in recent years.

Mersey Community Hospital (MCH)

The MCH was originally built in 1962 and is a four-level health facility providing acute and sub-acute hospital services in the North West of Tasmania. It is fully accredited by the Australian Council on Health Standards (ACHS) and is the elective surgery and sub-acute hub for the North/North West.

From 1 July 2017, the ownership and funding for the MCH was transferred from the Australian Government to the Tasmanian Government, to be operated by the THS.

The One Health System reform agenda continues to be implemented at the MCH. A range of changes to the MCH's service profile are continuing to progress, including provision of antenatal services and rehabilitation services. The implementation of these changes will require significant capital works.

Prior to ownership of the MCH returning to the Tasmanian Government, the THS and DHHS undertook a site master planning exercise to better understand the implications of implementing the full range of expected service changes to the site as envisaged within the One Health System reforms.

The 2017-18 Tasmanian Government Budget includes an allocation of $35 million addressing the program of projects identified. The redevelopment will expand the range and capacity of sub-acute services for improved health care in the Mersey Leven and broader catchment area, providing new and improved health facilities for the delivery of enhanced health services.

North West Regional Hospital (NWRH)

The NWRH has undergone significant refurbishment over the past four years with a new ED, Rehabilitation Ward, Palliative Care Beds and the Integrated Cancer Centre which offers Radiation and Medical Oncology. Several of the ward areas have also had refurbishments including new floor coverings and painting during this time.

As part of supporting the local North West Community to travel between sites for services, a Hospital Link bus service has also been implemented between MCH and NWRH. This is supported by bus lounges at both sites for people waiting to use this service. NWRH also has visitor accommodation located on site for eligible patients and carers.

Telehealth

The Patient Transport, Care Coordination and Accommodation Project includes a telehealth expansion initiative to improve the use of telehealth in the delivery of clinical services so that, where appropriate, patients can access health services without having to leave their home or local community. The project is supporting existing telehealth services, facilitating the opportunistic use of telehealth and supporting early adopters of telehealth. To support this work, 52 outpatient clinic rooms will be telehealth-enabled to facilitate and encourage the uptake of substituting face to face consultation with telehealth.

Causes of Capacity Constraints

There are a variety of reasons why the acute sector sometimes operates above capacity. The main factors, some of which are covered in more detail in other areas of this submission, include:

Australian Government Funding Arrangements

The 2012 National Health Reform Agreement focussed almost solely on the acute services sector, with funding to states being linked to their level of public hospital activity. Preventative programs were defunded. Secondary and tertiary prevention programs that delivered acute diversion, acute substitution and community based anticipatory care programs were deemed to be out of scope for Australian Government funding. Funding arrangements are discussed further in Section 4.

Medicare rebates for GP visits

The Medicare Rebate for visits to GPs was frozen by the former Labor Australian Government in 2013 and indexation for standard consultations by GPs will not resume until 1 July 2018. This extended freeze has increased the out of pocket expense for people visiting their GP and also resulted in a large number of GPs ceasing to provide bulk billing of their services. This has created a strong price signal for the community to attend public hospital EDs for free, rather than paying to visit their GP.

Workforce

The One Health System White Paper identified a number of issues with Tasmania's health workforce. These included:

- peaks and troughs in workforce supply;
- a large range of services with low volumes and single person dependencies; and
- a health workforce development system that is largely under-planned, driven by immediate operational decision-making, and poorly aligned with universities and other education providers.

The White Paper recognised that making better use of our health professional workforce, by introducing new models of care that use the full range of their skills and expertise, in particular in the nursing, midwifery and allied health workforce, has the potential to provide a more efficient overall health service. The ECPs discussed in the previous section are one such example.

A critical workforce issue relates to hard-to-recruit specialist doctors, nurses and allied health staff. The current models of care rely on having those specialist staff available in certain areas, but experience over an extended period (in some cases 20 to 30 years) has revealed that it is extremely challenging to recruit permanent staff to those positions. This has resulted in a high reliance on locums and restricted access to services at a point where an acute admission could be avoided. The One Health System reforms aim to address this issue, for example by fostering greater collaboration between surgical services across the State, with the initial priority being collaboration across the North and North West. Surgical services working together will improve the quality and safety of the services across the State, improve access to some services in the North West and build a larger, more sustainable surgical service for Tasmania.

The North West Coast has recently seen improvements in hospital staffing, with four new permanent consultants appointed at the NWRH. At the MCH, it is expected that the additional certainty brought about by ownership of the hospital returning to the Tasmanian Government will make it easier to recruit permanent medical staff. There already has been significant progress on this front, with a General Physician/Stroke Specialist now permanently based at the MCH and five permanent doctors recently recruited to the MCH ED.

The TRDF provides clarity regarding the minimum levels of workforce required for the safe delivery of clinical services. This, combined with the statewide focus under one THS provides opportunity to develop a planned approach to a health workforce that will more closely meet the health service needs of the community in partnership with education providers, primary care and the private hospital sector.

Elective Surgery

The Commission made particular mention of Tasmania's legacy of long waiting lists for elective surgery. When the Government was elected in 2014, Tasmania had the worst performance of any jurisdiction in relation to elective surgery. Substantial investment has been made to improve that performance, which has resulted in a significant increase in the number of surgeries performed and a corresponding reduction in patients waiting longer than clinically recommended times. Having dramatically reduced the problem of long waiting times for elective surgery, the next stage in improving the performance of this sector will require a strong focus on reducing the use of inappropriate and/or low value elective procedures in Tasmania, and on developing effective care pathways to and (where appropriate) non-surgical substitutes for surgical interventions.

Alternatives to hospital treatment

As discussed in other sections, in order to manage and reduce demand for acute services, it is important that the primary and community health system is developed and fully utilised where appropriate to safely manage illness in the community. A lack of services that can deliver high acuity services within the home, such as the ComRRS trial described in section I and rehabilitation-in-the-home, places additional pressure on the hospitals and limits their ability to manage surge in demand.

4 Term of Reference 3 – The adequacy and efficacy of current State and Commonwealth funding arrangements

Summary of Current Funding Arrangements

Healthcare funding arrangements in Australia are complex, relying on multiple funders and funding methods. The ways that governments pay for healthcare services impact directly on the appropriateness, timeliness and accessibility of healthcare and the health outcomes of individuals. The complexity of Australia's funding arrangements is recognised as a barrier to improving system efficiency, simplicity and achieving patient-centred healthcare.

Current funding arrangements are fragmented and duplicative, impacting on patients, providers and funders, and jeopardising the sustainability of the broader healthcare system. Policies and programs are often designed in isolation from one another, even though patients access services across boundaries and between programs.

Current funding arrangements do not sufficiently reward quality outcomes and patient experience. The existing national activity based funding (ABF) system promotes increased efficiency in the delivery of public hospital services by paying an efficient price for each service delivered, thus sending a price signal to public hospitals to review their cost structures and identify opportunities to provide services more efficiently. Undoubtedly, this is one of ABF's strengths. However, in an environment where demand for acute services continues to increase, it does prioritise throughput over quality and outcomes. ABF focusses the system on the delivery of more acute admitted episodes and provides few incentives for investment in prevention, early intervention and the development of substitutes for acute admitted care in community settings.

Like the rest of Australia, Tasmania is experiencing a transition where the burden of disease is shifting from episodic and acute conditions towards illnesses that are chronic, complex and lifelong. Addressing the rise of chronic disease is a difficult challenge, but made more difficult in Australia because of the fragmented and duplicative funding arrangements and dispersed responsibilities for service delivery; no one layer of government has the necessary levers to address the funding challenges posed by chronic disease.

Current funding arrangements are generally not patient or community centred. A patient's needs are rarely confined to a single provider or funder. Instead, patients interact with different healthcare sectors across different funding streams. Current funding arrangements are not responsive to patient's needs, focussing on disease-specific responses rather than more holistic, community centred approaches to funding that support patients and providers to address healthcare needs through a lifetime.

In an effort to address these deficiencies, future reforms to the national health financing framework and current funding arrangements are under consideration at a national level. These reforms include:

- the incorporation of value based measures into funding models, building on existing programs such as pricing for safety and quality (e.g. no payment for sentinel events) to include clinical outcomes and patient reported experience and outcomes;
- the expanded use of bundled payments (where a single price is determined to cover a full package of care over a defined period of time, spanning multiple events and settings of care); and
- blended funding at a provider level, allowing multiple sources of funding for primary care, allied health, specialist care, acute care and restorative aged care to be pooled by individual providers to provide "wrap around" care for patients and communities.

While there is a need to continue to refine the ABF and the Tasmanian model of funding activity, there is also an increasing need to develop a funding approach more appropriate for those with lifelong (chronic and complex) conditions[11]. This is particularly the case in Tasmania, where 3 904 hospital patients were diagnosed with six or more of these conditions in 2015 (see section 6).

Tasmanian Funding Model

Tasmania applies the existing national ABF system, with additional block grants provided for services that are out of scope for ABF.

The national ABF system promotes improved efficiency in the delivery of public hospital services by paying an "efficient price" (the National Efficient Price, or NEP) for each service delivered. Patient care which is clinically similar and resource homogenous is grouped into "classes" which receive a single price based on the average cost of an episode of care for each class. All public hospital services funded on an activity basis receive a national weighted activity unit (NWAU) weighting.

[11] An example of these outcome and value based funding mechanisms is: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf

The average admitted acute hospital service is equivalent to one NWAU. The most intensive and expensive services (such as Intensive Care Unit stays) attract a higher NWAU weighting and the simplest and least expensive services (such as renal dialysis) attract a lower weighting. Not all patients receive the same NWAU. Public patients receive a full NWAU, private patients in public hospitals receive a discounted NWAU to account for private patient revenue, and patient types such as the Department of Veterans Affairs and Motor Accidents Insurance Board receive a value of zero NWAU to account for revenue derived from those alternative sources.

For 2017-18, the Independent Hospital Pricing Authority (IHPA) has set the NEP at $4 910 per NWAU. To determine the NEP and NWAU, IHPA uses national average weighted costs as a basis and undertakes several adjustments that remove costs and applies loadings for some other factors.

While Tasmania's costs for admitted acute hospital services are higher than the national average weighted cost, the most recent available National Health Cost Data Collection (NHCDC) report for 2014-15 shows that against a background of expenditure increasing at a greater rate than population growth, Tasmania's costs are moving closer to the national average. Tasmania was 2.8 per cent above the national average for 2014-15, compared to 6.4 per cent above the national average in 2012-13.

As outlined above, while the main advantage of ABF is that it promotes increased efficiency in the delivery of public hospital services, and it is therefore widely considered a more efficient way to fund hospitals than block funding (which provides little incentive to improve quality or reduce costs), there are several disadvantages to ABF as it is currently implemented, including:

- it provides incentives to increase activity and perhaps "over service" patients;
- it favours treatment rather than prevention or avoidance of a hospital stay;
- it takes no account of actual patient outcomes; and
- it can encourage unnecessary hospital admissions by only funding episodes of care that are provided in an acute setting.

All jurisdictions have signed an Addendum to the NHRA which commits to the extension of ABF arrangements until at least 30 June 2020. Negotiations for longer term funding arrangements are to commence in 2018.

Australian Government Funding

The Australian Government provides funding for public hospital services under the NHRA. The NHRA was agreed in 2011 and amended in 2017 to reflect a 2016 Heads of Agreement.

Under the NHRA, funding for public hospital services is provided on an ABF basis 'wherever practicable', with some services receiving a block grant where this is more appropriate. This funding is provided directly to Tasmanian hospitals. The funding is calculated based on the amount paid to each state in the previous financial year, plus 45 per cent of the efficient growth in activity. For ABF based services, the efficient growth is calculated as the growth in NWAU multiplied by the NEP.

Through the 2016 Heads of Agreement, the Australian Government has committed to continue funding 45 per cent of the efficient growth in activity for the period 1 July 2017 to 30 June 2020, with the maximum growth capped at 6.5 per cent per year. However, Tasmania negotiated a bilateral guarantee with the Australian Government that ensures the State will receive no less than the minimum annual growth that it would have received under the 2014-15 Federal Budget indexation proposal, which would have seen hospital funding to states indexed by the Consumer Price Index and national population growth.

It is important to provide quality hospital services to those who need it. However, research has shown that better outcomes for patients are achieved where care can be provided outside of the hospital setting. Therefore, as part of the Heads of Agreement, all jurisdictions agreed to take action to:

- reduce the demand for hospital services through better coordinated care for people with complex and chronic conditions; and
- reduce the number of avoidable hospital readmissions, in part by introducing hospital pricing mechanisms that reflect the safety and quality of services provided.

Based on the 2017-18 Federal Budget, public hospital funding to be received by Tasmania from the Australian Government is shown in table 4.1 below:

Table 4.1: Estimated Hospital Services funding from Australian Government to Tasmania.

2016-17 Estimated outcome ($m)	2017-18 Budget ($m)	2018-19 Forward Estimate ($m)	2019-20 Forward Estimate ($m)	2020-21 Forward Estimate ($m)
362.1	385.5	399.8	414.6	441.2

Source: 2017-18 Federal Budget Papers.

In 2013-14, the financial year in which the Government came to office, Australian Government hospital services funding to Tasmania was $292.4 million.

The actual amount of funding to be received by Tasmania from the Australian Government over the next three years will depend on hospital activity during that time. Current estimates of hospital activity for 2018-19 and 2019-20 are at a level which would activate the funding guarantee. For this reason, the Federal Budget allocates guarantee funding to Tasmania of $300 000 and $400 000 respectively in those two years. These amounts are indicative only and will depend on actual activity.

Tasmanian Government Funding

The State Budget provides for State funding to the THS to be indexed at 2.5 per cent per annum. Mersey Funding is indexed at 3.5 per cent, as per the new agreement with the Australian Government. Additional funding may be allocated through standard budget processes if required.

System Manager

The Tasmanian Government, through DHHS, is the system manager. As the system manager, DHHS has prime responsibility for ensuring that admitted acute services purchased from the THS are planned and funded appropriately to meet the needs of the Tasmanian population.

The type and volume of acute services to be purchased from the THS are outlined in an annual service agreement. The 2017-18 service agreement was signed by both the Minster for Health and the THS Governing Council Chairperson in June 2017. It was developed in accordance with the DHHS Strategic Purchasing Framework (the Framework) which comprised a planned approach to planning and purchasing to deliver on the 2017-18 Service Agreement. The Framework included focused work to identify a number of issues and objectives of the highest priority from the perspective of the Tasmanian Government (e.g. actions required by the White Paper) while also addressing the areas of greatest potential for benefit from changing care and delivery models.

Key outputs of the Framework included:

- a Statement of Purchaser Intent (SoPI) based on quality data relating to the burden of disease;
- a mechanism for modelling future needs and demand growth to generate forward activity estimates;
- an improved funding model (the Tasmanian Funding Model) that utilises data of improved quality to drive a range of key functions;
- a service agreement that is a vehicle through which improved health care outcomes and improved value for money can be purchased (from the THS or other providers); and
- a fit for purpose performance assessment and reporting framework that drives strategic purchasing of health services in line with Government's strategic objectives.

During the development of the 2018-19 service agreement the processes and methodology underpinning these outputs will be documented into a formalised transparent purchasing framework for 2018-19 and beyond.

Future iterations of the SoPI will focus on the identification of further opportunities for improved efficiencies and targeted purchasing decisions. These may include an increased focus on those conditions that provide the greatest burden of disease for Tasmanians (AIHW, 2011). These are (in no particular order):

- respiratory disease.
- neurological conditions.
- cardiovascular disease.
- cancer.
- injuries (which include suicide).
- musculoskeletal conditions.
- mental health and substance abuse.
- oral disorders.
- hearing and vision disorders.
- diabetes.

Addressing the risk factors associated with these conditions will be a priority, as addressing risk factors will those people who have multiple chronic conditions.

5 Term of Reference 4 – The level of engagement with the private sector in the delivery of acute health services

Summary of Private Sector Engagement

Tasmanian public hospitals have always contracted a proportion of activity to private hospitals. Utilisation of private hospitals rose marginally to four per cent of inpatient separations in 2015-16, up from about three per cent in preceding years. This primarily reflects use of private hospitals to provide additional elective surgery capacity.

It is important to note that engagement with private health organisations is not limited to engagement with private hospitals. PHT is a key private sector partner for the public health system. As highlighted in Section 2, an acute system cannot operate efficiently without effective integration or care between all health services in the care continuum. Engagement with primary health services is particularly important with regard to management of demand, to give referral pathways for patients to and from GPs and for the development of demand management actions focused around acute substitution, acute diversion and anticipatory care. Research, teaching and training institutions are also key partners in healthcare.

Maternity Services in North West Tasmania

As part of the One Health System reforms, it was identified that an alternative model was required in the North West in order to provide a stronger, higher quality birthing and maternity services. After extensive consultation with all stakeholders, a new service was established with public inpatient and birthing services delivered by the North West Private Hospital in Burnie and antenatal and postnatal care delivered by the THS at the Mersey Community Hospital, the North West Regional Hospital in Burnie and at a number of other rural sites via outreach services.

Continuing engagement between the THS and the North West Private Hospital will be required to ensure that the inpatient and birthing service at Burnie is of the highest quality and is seamlessly integrated with the antenatal and postnatal services provided by the THS.

Elective Surgery Panel

For many years Tasmania demonstrated the longest waiting times and poorest elective surgery access performance of all states and territories. For more than a decade, a large proportion of all patients had waited longer than clinically recommended (in terms of nationally agreed wait times). This problem of over boundary patients had become endemic in Tasmania's public hospital system. Periodic attempts to make progress through one-off funding injections for elective surgery "blitzes" had failed to shift this long term trend.

During 2014, the opportunity arose to improve purchasing arrangements. Firstly, Australian Government funds became available to DHHS for elective surgery delivery and reform under the Tasmanian Health Assistance Package (THAP). In particular, DHHS was able to cover travel costs of sending patients interstate for treatment. Secondly, at the same time, the Tasmanian Government committed significant funding to elective surgery and pledged to transform performance in this area under its Rebuilding Health Services Tasmania package.

Given this funding commitment, and the learnings acquired in previous years, it was clear that an innovative approach was critical to make the most of this unprecedented opportunity for transformation, and to avoid repeating the failure of previous one-off funding injections and blitzes. The crucial elements required to deliver a successful transformation of performance were:

- strict targeting of funding towards treating the longest waiting patients, and to prevent diversion of funds into treating new demand, and
- use of the private sector to provide additional capacity that could be increased or decreased without adding to the fixed costs of the THS.

In September 2015, following an extensive development process to undertake a competitive procurement, DHHS established a new Panel arrangement for purchasing elective surgery services from private hospitals in Tasmanian and interstate.

Establishing the elective surgery panel was a key element in achieving the Tasmanian Government's goal of transforming Tasmania's excessively long waiting times for elective surgery, with the following objectives:

- To establish effective contestability in the market for elective surgery in Tasmania.
- To provide additional capacity to treat record numbers of long waiting patients.
- To provide access to interstate private hospital capacity, in order to avoid overloading local private hospitals.

No competitive procurement of clinical services had previously been undertaken on this scale by DHHS. The procurement exercise was designed with a number of innovative improvements, including use of the NEP as a reference point for the pricing of tenders, built in arrangements for pre and post-operative care, and the development of clear quality criteria for the flow of patient information.

Under the arrangement, 850 patients have received their surgery. All had waited for long periods for their surgery – often more than two years. Of these, 320 received treatment interstate, less than two per cent of total surgeries performed during that time. There is no question that the Panel delivered direct impact, but also a secondary impact through driving improved THS performance. Along with the efforts of the THS in improving its performance, the Panel arrangement was instrumental in reducing the number of long waiting patients and overall wait times to unprecedented low levels.

Licensing of private health services

DHHS is responsible for licensing and monitoring private hospitals, private day procedure centres and private residential care services in Tasmania. This is carried out under the authority of the *Health Service Establishments Act 2006* (HSE Act) and the *Health Service Establishments Regulations 2011* (HSE Regulations). The Secretary of DHHS (the Secretary) is the Regulator of private health service establishments under the HSE Act and is responsible for licensing decisions. In this role, the Secretary is supported by the DHHS Regulation Unit and a statutory committee, the Health Service Establishments Advisory Committee.

The object of licensing is to ensure:

- the quality and safety of services by private providers by specifying the standards to be met by licence holders; and
- that services are provided to effectively meet the needs of Tasmanians in accordance with clinical practice guidelines and best practice standards.

The HSE Act and HSE Regulations specify certain standards which must be met for licensed facilities including those for achieving accreditation, credentialing staff, safety and quality standards, operational procedures, medication management, infection control, incident reporting, fire and environmental safety, record keeping and equipment maintenance.

DHHS currently licenses 20 private health service establishments in Tasmania, consisting of eight private hospitals, and 12 licensed day procedure centres. In undertaking this regulatory function, DHHS, through the Regulation Unit, follows best practice approaches, including building collaborative relationships with licensees, managing stakeholder expectations through open and transparent communications and ensuring regulation contributes to better health outcomes for all Tasmanians.

The regulatory approaches used by DHHS in the licensing and monitoring of private health services focus on efforts to:

- achieve key policy objectives;
- minimise the regulatory burden;
- adopt risk-based approaches to target compliance activities; and
- demonstrate transparency and accountability.

The process for licensing is set out in the HSE Act and involves an application to the Secretary (as the Regulator of private health services). Applications are first considered by the Health Service Establishments Advisory Committee (the Committee) in accordance with the requirements of the HSE Act. The Committee is required to consider:

- any relevant health service planning guidelines;
- the critical mass of patients required to comply with clinical practice throughout Australia and with any guidelines as to the provision of services;

- any other similar matter that the Committee considers to be supported by expert opinion;
- the current availability of services in the local area; and
- the suitability of the applicant to provide such services.

Where an applicant can demonstrate it meets the above considerations, including any necessary specialist appointments and the development of necessary infrastructure, the Secretary may issue a licence. All applications for new licences are required to be publically advertised and all interested stakeholders are able to comment on applications through this process. In addition, feedback is often sought directly from the THS and its clinicians during the application assessment process (although the THS does not have the ability to prohibit or delay the establishment of a private health service).

Provision of acute services by private hospitals

The regulatory and licensing framework in Tasmania allows private hospitals to provide the majority of acute services, so long as they can demonstrate their ongoing ability to deliver a safe and quality service in line with the licensing standards applicable to it. The HSE Regulations prescribe a set of 'classes' for private hospitals and day procedure centres. The five prescribed classes for private hospitals are General, Surgical, Maternity, Psychiatric and Rehabilitation. The three prescribed classes for day procedure centres are Low Risk / Minimally Invasive, Surgical and Endoscopic. The HSE Regulations prescribe a set of licensing standards for each class of private hospital and day procedure centre.

In addition to prescribing classes, the HSE Regulations also prescribes a number of 'specialised services' which can only be performed by a service whose licence has specific authorisation. Currently the following specialised services have been authorised to be performed in Tasmanian private hospitals:

- emergency services;
- maternity services;
- intensive care;
- coronary angioplasty and cardiac catheterisation;
- neurosurgery; and
- psychiatric.

6 Term of Reference 5 – The impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services

Overview of Adverse Events and Outcomes

Adverse events are defined as incidents in which harm resulted to a person receiving health care that causes premature death, prolongs the hospitalisation, produces a disability at the time of discharge, or both the latter. Some of adverse events may be preventable.

Adverse events contribute to poor patient outcomes, but not all poor patient outcomes are attributable to adverse events.

With respect to poor patient outcomes, there are a number of hospital activities that are reported nationally for which Tasmanian data is available on patient outcomes in the delivery of acute health services. Measures of safety and quality in health care provision include re-admissions rates, falls, infections and in-hospital mortality rates.

While the majority of hospital deaths do occur in the public sector, this is not a reflection on the quality of care provided but rather the stage of illness, and the acuity and/or complexity of illness with which the patient presents. Patients receiving care in the private sector tend to be elective admissions, which also tend to be of lower complexity than that of the public sector. In addition, some higher risk surgical procedures are only performed in public hospitals in Tasmania.

Patients with multimorbidities have higher risk of complications when receiving health care. A significant proportion of surgical deaths in Australia occur in patients with at least one comorbidity and almost two thirds of surgical deaths occur in patients with two or more comorbidities. In recognition of this issue, this section includes a discussion on the prevalence of and issues associated with managing patients with multimorbidities.

Adverse events and poor outcomes also cause the hospital system to be inefficient, including increased length of stay, unplanned readmissions and potentially more interventions as a result of complications. In the future, models of pricing and funding for safety and quality will be adopted in Australia, aimed at reducing avoidable re-admissions to hospital, sentinel safety events and hospital acquired complications. This is discussed further below.

Tasmanian outcomes data

Unplanned/unexpected re-admissions

Nationally, unplanned/unexpected re-admissions are reported for only seven surgical procedures. Unplanned or unexpected readmissions after surgery is a measure of the safety of care in hospitals and it can also be regarded as an indicator of effectiveness of care. High rates of re-admission reflect hospital quality of care issues, including discharge planning, and can be considered a signal for further investigation.

It is important to note that access to primary care, the quality of primary care and clinical communication between acute and primary care providers also influence re-admission rates.

Unplanned/unexpected re-admissions are a count of separations for which a readmission occurred to the same hospital within 28 days of selected surgical procedures. In 2015-16, Tasmania's re-admission rate per 1 000 separations for all selected procedures was higher than the national rate (AIHW). However, for most procedures the re-admission rate was lower than in 2012-13.

RHH Mortality Review

The THS Governing Council, through the its Quality and Safety Sub-Committee, commissioned Dr Kelly Shaw of KP Health Consulting to review mortality data at the RHH as a result of concerns raised by clinicians around mortality rates.

The study undertook to:

- compare RHH data for three mortality measures for the period 1 January 2016 to 31 March 2017 to identify potential methodological (non-clinical) issues impacting on mortality results, and
- undertake a review of the clinical record of all patient deaths in the clinical categories with the highest attributed mortality.

The study concluded that there is no evidence of serious safety issues at the RHH and that across all three metrics of mortality the data has remained stable over the last four years.

Primary factors contributing to adverse patient outcomes

The contributing factors identified below have been defined and discussed within the context of the actions required to ameliorate them. This includes the actions that the Government has taken to address concerns, including those of the Commission.

Existing health status and other risk factors

There are two main bodies established in Tasmania that undertake external review of morbidity and mortality in Tasmanian hospitals. The Tasmanian Audit of Surgical Mortality (TASM) is a joint initiative between the Royal Australasian College of Surgeons and the Department. It is an external, independent peer process that reviews the clinical management surrounding deaths that occurred during surgical admission. The Council of Obstetric and Paediatric Mortality and Morbidity (COPMM) also investigates the circumstances surrounding, and the conditions that have or may have caused maternal or paediatric deaths and investigates or reports on obstetric or paediatric mortality or morbidity issues.

As previously discussed, patients with multimorbidities have higher risk of complications when receiving health care. The majority of Tasmanian surgical deaths occur in elderly patients with underlying health problems, who have been admitted via the ED with an acute life-threatening condition. Causes of death were often linked to pre-existing health status. In these cases death was almost always assessed by the Tasmanian Audit of Surgical Mortality (TASM) review process as being not preventable, or to be a direct result of the disease processes involved rather than the treatment provided. The most common causes of death reported were multi-organ failure, septicaemia and respiratory failure. This is congruent with the most common comorbidities in this series of patients and is similar to the national audit findings reported in the most recent Australian and New Zealand Audit of Surgical Mortality National Report 2014.

The leading causes of indirect maternal deaths in Australia, New Zealand and the United Kingdom are pre-existing medical conditions and cardiovascular disease. This is expected to continue with increasing maternal age, maternal obesity and other medical risk factors in the obstetric population. Comorbidities/multimorbidities and life styles choices that impact in other areas of health also impact upon maternal and paediatric health.

Maternal smoking is associated with increased risk of stillbirth, premature birth and low birth weight. Low birthweight is also a significant risk factor for cardiovascular disease, type 2 diabetes and kidney disease in later life. In 2014, 14.3 per cent of all Tasmanian mothers reported smoking whilst pregnant (with higher rates reported amongst teenage mothers at 34.9 per cent). For the same year a total of 14.5 per cent of all women who had smoked in pregnancy had a low birth weight baby compared to 5.4 per cent of women who reported not to have smoked.

Obesity is another area of concern. Pregnant women who are obese have an increased risk of thromboembolism, gestational diabetes, pre-eclampsia, post-partum haemorrhage, wound infections and caesarean section, and their babies have higher rates of congenital anomaly, stillbirth and neonatal death compared with pregnant women who are not obese (Hilder, Zhichao, Parker, Jahan, and Chambers, 2014). Tasmania has a higher proportion of obese women who give birth than the national average. Based on self-reported height and weight, 46.7 per cent of the 5 427 women who gave birth in a Tasmanian facility in 2014 had an overweight or obese body mass index (BMI) (25.0 and above) with almost a quarter (22.7 per cent) having an obese BMI (30 and over, at first antenatal consultation). However, these figures are lower than recorded in 2014-15 (based on measured height and weight) for Tasmanian women as a whole aged 18 years and over.

System sustainability

The Commission outlined the essential characteristics of a sustainable health system. These include:

- patient safety and clinical quality is ensured through quality management systems;
- resources flow in accordance with long term planning, rather than in response to short term events;
- roles are clearly delineated and understood;
- there is strong governance, enabling change and ensuring that people are accountable for their actions;
- fragmentation is avoided and care is taken to guard against the formation or perpetuation of unresponsive, disconnected silos within the system;
- all sectors of the health system work together, placing the patient at the centre of their concerns; and
- healthcare workers implement evidence-based best practice.

The Government received the Commission's report soon after being elected in 2014 and recognised that Tasmania's health system lacked many of these characteristics. It was apparent that in order to provide safe, effective and sustainable services in Tasmania, the discussion needed to shift from "better access to services" to "access to better services". This is a key focus of the One Health System reforms.

A key part of the Government's focus is ensuring that Tasmania has an effective and responsive primary care sector to promote wellness, limit the long-term impact of complex and chronic conditions, keep people out of hospital, and ultimately, improve the quality of life of Tasmanians. This involves:

- having a greater focus on primary and community care;
- shifting the balance of care provision from the hospital to the community;
- redesigning clinical services;
- strengthening public-private partnerships; and

- strengthening interstate partnerships.

The first phase of acute system reform is to define the capacity and capabilities health facilities to provide safe and sustainable clinical services of defined complexity. To this end, the Tasmanian Role Delineation Framework (TRDF) describes where services in each discipline will be delivered. It is underpinned by the following principles:

- the facility must be able to sustain a competent and high performing clinical workforce, infrastructure and support services required to provide care that is consistent with best practice;
- appropriate minimum service volumes must be maintained to ensure the competence and professional practice of the multidisciplinary team can be sustained;
- Tasmanians must be able to access services which are determined by the facility's ability to deliver consistently safe, high quality care, rather than on considerations of proximity;
- relying on small numbers of clinicians to be on call 24 hours a day, 365 days a year to maintain a service is neither safe nor sustainable. Workload needs to be sufficient to engage multiple clinicians across the range of necessary disciplines in the delivery of a quality sustainable service. Services with key person dependencies must be redesigned to ensure quality, safety and sustainability; and
- care must be continually improved. The impact on patient outcomes and experience must be continually monitored, reviewed and evaluated. Tasmanians should expect to receive care comparable with national and international standards.

The TRDF has been followed by mapping of services to determine a valid Tasmanian Clinical Service Profile (TCSP).

Culture

The Commission noted in its report that while there is a general acceptance that a sustainable health system requires acceptance of personal responsibility for well being and greater emphasis on preventative care, until this transformation takes place, patients will still require treatment in the acute setting. Balancing this dual role of implementing reform to ensure long term sustainability while continuing to meet current needs will require widespread engagement, effective governance and appropriate use of information.

Appendix I includes an extract from the report regarding the Commission's observations of the culture of the Tasmanian health system during the time it researched its report. This indicates the challenge of implementing reform in the Tasmanian health system.

The TASM Annual Report 2015 (the most recent local report released) identifies areas that require particular focus to improve surgical outcomes. DHHS and the THS are actively working towards improvements in the identified areas, which are:

1. In complex cases there must be clear demonstrable leadership in patient management.

2. Better documentation of care plans and clinical events – the current focus is on improving data capture in medical records and discharge summaries.
3. Action on evidence of clinical deterioration – the current focus is on Medical Emergency Team criteria and standardisation across the THS.
4. Improved preoperative management.
5. Improved postoperative management.
6. In-hospital fall prevention – the current focus on performing risk assessment on patients and using risk reduction strategies for patients identified as at risk.
7. Improved awareness of surgical emergencies and sharing of care.
8. Improved communication.

Information and communication regarding poor outcomes in of itself does not improve future patient outcomes. Systems and processes must be in place to ensure that the system is responsive and that clinicians are actively involved in finding solutions to issues in a culture of continuous improvement.

The THS Ministerial Charter includes the requirement for a Clinical Governance Framework. The Tasmanian Clinical Governance Framework for Tasmania's Healthcare System (the Clinical Governance Framework) was endorsed in September 2013. The One Health System White Paper identified that a lack of acceptance of the Clinical Governance Framework across segments of Tasmania's public health care system was hampering implementation and accountability. In early 2016, a review of the Clinical Governance Framework was commenced at the request of the Tasmanian Minister for Health. Work is ongoing to develop and implement a new Quality Government Framework. A culture of continuous improvement will still be required for the implementation of the new framework to succeed.

Patients with multiple morbidities

Australian, like most developed countries, has an ageing population, driven in part by increasing life expectancy. This ageing population, combined with advances in medical management has resulted in a rise in the number of people living with multiple chronic conditions (multimorbidities). This national trend is reflected in the Tasmanian population. The trend of increased multimorbidities is resulting in increasing complexity (as opposed to acuity) in the treatment and management of patients.

The following data relate to patients with three or more chronic conditions.

Prevalence estimates from the primary care sector indicate that between 25 per cent and 32.6 per cent of the Australian population are living with multimorbidities (three or more self-reported chronic conditions) (Britt et al. 2008; Harrison et al. 2016). Prevalence rates for multimorbidities have been shown to significantly increase with age, with international research suggesting that rates may exceed 60 percent among people over the age of sixty five. Internal DHHS data indicates that in 2015, 3 904 Tasmanian hospital patients had six or more chronic conditions.

Patients with multimorbidities have higher rates of health care utilisation and are at greater risk for further complications and mortality. The cost of care required by patients with multimorbidities is also higher (Wang et al. 2017; Weir et al. 2015).

The increased risk of complications, mortality, and cost to the health system for patients with multimorbidities is evident in Tasmania's acute admitted data. These data (Appendix 3: Table 10) show that grossly multimorbid patients (those identified as having six or more chronic conditions) have more than twice as many hospital episodes as other patients (1.8 versus 4.6 episodes); stay in hospital for longer, and are more likely to experience hospital acquired complications.

Anecdotally, the complexity associated with the treatment of patients with multimorbidities causes inefficiencies in health care systems that are designed around single disease/condition care, and has a multiplier effect on the care requirements of those patients. For example, when undergoing surgery, patients with multimorbidities take longer to anaesthetise, longer to operate on, and have higher risk of complications and longer recover time.

The increase in patients with multimorbidities presents a challenge for health care systems which, as noted above, are largely designed and funded for single conditions. It is more difficult for patients with multimorbidities to navigate the system and for clinicians to treat and manage these patients. Across developed country health systems there is increasingly a rise in health care roles broadly focused on facilitating coordination of care and helping patients to navigate health care systems (and health practitioners to navigate patient care), and calls for information and communications technology solutions with complex workflows capabilities. These initiatives are symptomatic of the increasing complexity in the patient population and highlight that system design, commissioning, policy and funding models need further work to enable health systems to better keep pace with the evolving morbidity profile of the community.

DHHS will continue to progress work to address the issue of multimorbidity, including through the SoPI.

Pricing and funding for safety and quality in health care

Under the Heads of Agreement for Public Hospital Funding (see Section 4) states and territories and the Australian Government agreed to work with the Independent Hospital Pricing Authority to develop a risk-adjusted model to integrate safety and quality into hospital pricing and funding. The aim of this reform is to reduce avoidable re-admissions to hospital, sentinel safety events and hospital acquired complications. The Tasmanian Government, through the DHHS has been an active contributor to the national work to design the technical specifications for risk adjustment, data capture sources, and funding reduction models in addition to defining the clinical materials required for this piece of work. From 1 July 2017 the Australian Government will no longer fund a hospital episode that contains an event from the National Sentinel Event list. As there are relatively few events that fit the national sentinel event list, there is not significant financial impact, however, this does send a signal that events that should never occur in our hospital system will not be tolerated and aligns with public expectation that public funding should not go towards care that results in harm.

The Tasmanian Government is continuing to work at multiple levels and within multiple areas of the DHHS on two other pricing and funding for safety quality initiatives – avoidable re-admissions to hospital and hospital acquired complications – which will be implemented in the next 12 to 24 months.

7 Term of Reference 6 – Any other matters incidental thereto

The Tasmanian Government does not have any comments in relation to this Term of Reference.

8 Mental Health

As the Committee's terms of reference explicitly includes Mental health, this section provides an overview of the mental health system in Tasmania, outlines the utilisation of and demand for admitted services, and highlights the action the Tasmanian Government is taking to reform the current system.

Tasmania's mental health system is complex and involves many stakeholders including people living with mental illness, their families and carers, the State, the Australian Government, public sector agencies, the private sector and community-managed organisations. It also overlaps with many services and sectors such as alcohol and drug services, acute services, emergency services, disability services, children and youth services, housing, justice, education and employment providers.

The Tasmanian Government is committed to meeting these challenges and developing an integrated Tasmanian mental health system that provides support in the right place, at the right time and with clear signposts about where and how to get help. One of the key aims of these reforms is to shift the focus of the Tasmanian mental health system from hospital based care to support in the community. To do this effectively requires collaboration across levels of government and across service settings.

Prevalence and impact of mental illness

Prevalence

Mental illness comprises a wide range of disorders and varies in its severity and duration. It is estimated that[12]:

- almost half of Australians will experience a common mental disorder in their lifetime;
- almost one in seven young people aged 4–17 were assessed as having mental health disorders in the previous 12 months;
- two to three per cent of Australians have a severe mental disorder; and
- 0.45 per cent of the population (or 64 000 people) aged 18–64 accessed treatment annually for a psychotic disorder[13] (based on 2010 population).

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[12] AIHW, 2017, *Prevalence, Impact and Burden,* Mental Health Services in Australia, 16 August 2017: https://mhsa.aihw.gov.au/background/prevalance/

[13] Psychotic illnesses are characterised by fundamental distortions of thinking, perception and emotional response. Psychotic disorders include schizophrenia, schizoaffective disorder, bipolar disorder and delusional disorder.

Impact

Mental ill-health can have enormous personal, social, financial and economic costs for individuals, families and for the community as a whole. This can include social isolation, breakdown of relationships, inability to work causing unemployment and financial distress, homelessness, stigma and discrimination. In addition, it is estimated that more than one in eight adults with a mental disorder in the last 12 months also experienced a physical disorder[14]. Mental and substance use disorders were the leading cause of non-fatal burden of disease, accounting for almost one-quarter of all years lived with a disability.

People with mental health conditions have higher probability of comorbid respiratory and neurological conditions. Management of these patients is a challenge for the system and is discussed further in section 5.

The configuration of Tasmania's mental health system

Like acute health services more broadly, funding for mental health services in Tasmania is provided through both the Tasmanian and Australian Government. Services are delivered in a range of settings, from primary and community care through to acute care.

Consumers and carers

People living with mental illness, their families and carers are the most important stakeholders in Tasmania's mental health system. Consumers are the users, past users or potential users of the system. Families and carers are in many ways the backbone of community mental health support. They can and do help people to recover and live well in the community.

Tasmanian Government funded services

The Tasmanian Government provides funding for public sector services and sets legislative, regulatory and policy frameworks for mental health service delivery. Public sector mental health services provide specialised care for people with mental illness. These include admitted patient services delivered in hospitals and services delivered in community settings.

Public mental health services are provided across Tasmania through the THS. Services include:

- 24 hour acute care units located at three public hospitals (RHH, LGH and NWRH);
- 24 hour older persons acute unit located in the south providing services to people across the state (Roy Fagan Centre);

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[14] AIHW, 2017, *Prevalence, Impact and Burden,* Mental Health Services in Australia, 16 August 2017: https://mhsa.aihw.gov.au/background/prevalance/

- 24 Hour Step up/Step Down facility located in the south (Mistral Place);
- 24 hour specialist extended treatment units located in the south and providing services to people across the state (Millbrook Rise Centre, and Tolosa Street);
- child and adolescent, older persons and adult community teams that operate across the state, adult community mental health teams also provide crisis assessment treatment and triage (CATT) services;
- a 24/7 statewide helpline triage service – the Mental Health Services Helpline; and
- Forensic Mental Health Services providing community and inpatient care for people with a mental health disorder, who are involved with (or at risk of involvement with) the justice system.

The Government now owns the community mental health facilities at Millbrook Rise in New Norfolk, Tolosa Street in Glenorchy and Mistral Place near the RHH. These were previously leased by the former Government, which created uncertainty regarding their ongoing future.

The Tasmanian Government also provides substantial funding to community-managed organisations for a range of activity including:

- psychosocial support services:
  - individual packages of care;
  - residential rehabilitation; and
  - community based recovery and rehabilitation;
- peer support groups;
- advocacy and peak body representation for consumers, carers and service providers; and
- prevention and brief intervention services.

Australian Government funded services

The Australian Government provides Medicare and grant-based funding and policy direction for the delivery of primary mental health care services delivered by private psychiatrists in the community, general practitioners (GPs), private psychologists, mental health nurses and other allied health professionals, as well as providing core funding to Aboriginal Community Controlled Health Services. It is also a funder of services delivered by the community-managed sector, both directly and through grants administered by Primary Health Networks (PHNs).

The Australian Government also has a central role in the infrastructure of the mental health system through funding research and telephone-based and digital service delivery initiatives, workforce initiatives in the tertiary education sector, Pharmaceutical Benefits Scheme (PBS) subsidised medicines and interfaces with key portfolio areas such as the Department of Social Services.

Community-managed sector

In Tasmania, the community-managed sector generally operates on a not-for-profit basis and is funded by both the Tasmanian and Australian Governments. It includes both large and small organisations, some with statewide coverage and many interrelationships, and some that operate in only one locality. These services often have strong connections with local communities and can engage those communities to deliver better social outcomes for consumers and carers. The 2017-18 State Budget provided $11.4 million for packages of care for the community-managed sector.

Private health sector

The private health sector provides professional fee-based services in both inpatient and office-based settings. These services can include primary care, acute management, rehabilitation, psychological interventions and other allied health based supports. Private sector professionals and organisations are substantial contributors to overall service delivery in mental health, and their funding is provided by a mix of patient fees and Australian Government rebates.

Expenditure on mental health services

Both the Tasmanian and Australian Governments have a role in funding mental health services in Tasmania. This core funding is supplemented by private health insurance rebates and patient fees.

National combined expenditure

Around $8.5 billion, or $361 per person, was estimated to be spent on mental health-related services in Australia during 2014–15[15], an increase from $343 per person (adjusted for inflation) in 2010–11 (2014–15 dollars).

$5.2 billion was spent on state and territory specialised mental health services, an average annual real increase of 2.3 per cent between 2010–11 and 2014–15. Of this, most was spent on public hospital services for admitted patients ($2.2 billion), followed by community mental health care services ($1.9 billion).

Expenditure on specialised mental health services in private hospitals was $433 million during 2014–15.

[15] 2014-15 Data is the latest nationally available.

Per capita expenditure for 2014-15 shows that Tasmania has the fourth highest per capita expenditure. There is $1.4 billion of Australian Government expenditure that cannot be attributed to states and territories, causing the discrepancy between the total per capita expenditure of $289.05 compared to the $361 noted above.

Table 8.1: Expenditure on mental health services by jurisdiction, 2014-15.

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
State and Territory	216.29	196.89	200.70	280.59	254.10	225.18	250.23	245.68	219.06
Medicare	44.61	53.31	44.48	31.12	42.57	38.45	35.81	11.41	44.51
Pharmaceutical	24.81	26.67	25.87	21.48	29.43	30.56	26.46	13.56	25.49
Total Per Capita	**285.71**	**276.87**	**271.04**	**333.19**	**326.10**	**294.19**	**312.51**	**270.64**	**289.05**

Tasmanian Government expenditure

Tasmanian mental health services receive funding of $117.9 million per annum from all sources. Around $25 million of this funds services in the community-managed sector and the regulatory and policy frameworks to provide mental health services, the rest goes into public mental health services.

Australian Government expenditure

The Australian Government paid about $1.1 billion in benefits for Medicare-subsidised mental health-related services in 2015–16, equating to 5.3 per cent of all Medicare subsidies. Expenditure on psychologist services (clinical and other) ($489 million) made up the largest component of mental health-related Medicare subsidies in 2015–16.

In addition, the Australian Government spent $564 million, or $24 per person, on subsidised prescriptions under the PBS/RPBS during 2015–16, equating to 5.0 per cent of all PBS/RPBS subsidies. Prescriptions for antipsychotics (49.6 per cent) and anti-depressants (36.5 per cent) accounted for the majority of mental health-related PBS and RPBS expenditure during this time period.

Utilisation of bed based services

Each jurisdiction across Australia has a unique publically funded service system as reflected in the tables below. The tables are drawn from AIHW Website, *'Mental Health Services in Australia'*, (https://mhsa.aihw.gov.au/home/) which is compiled from data provided by all jurisdictions through National Minimum Data Sets. The data are for 2014-15 (the latest available data).

The mental health service system in Tasmania is at the beginning of a significant reform process which will be informed by the Tasmanian Government's Rethink Mental Health Plan and the 5th National Mental Health Plan. Both of these documents are consistent in the need to increase regional integration across all components of the service system regardless of the funder and the need to move the focus from hospital based services to community care.

The tables below therefore describe the Tasmanian public mental health service system at a point in time in comparison to other jurisdictions. There are also gaps in the data that will be detailed below.

Table 8.2 shows where each jurisdiction allocates funding to address the mental health needs of its population. As can be seen, New South Wales spends double what the Australian Capital Territory spends on hospital bed based services, the Northern Territory spends 50 per cent more than Tasmania on community based services and Tasmania spends more on residential services than any other jurisdiction.

Table 8.2: Jurisdictional share of total expenditure by service type, 2014-15

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Hospital[16]	55.24	31.95	42.86	42.74	39.09	30.21	24.68	32.67	43.26
Community	32.21	36.59	44.68	39.56	42.51	30.80	40.95	45.53	37.65
Residential[17]	0.63	16.38	0.00	3.71	6.74	25.07	13.44	10.56	5.88
NGO[18]	5.59	9.21	8.11	6.93	9.24	9.14	18.06	6.80	7.68
Other	6.34	5.87	4.35	7.06	2.43	4.78	2.87	4.44	5.52

While this table broadly describes the general structure of each jurisdictions system, care must be taken in drawing definitive conclusions from this data as not all jurisdictions report on the same basis. For example, Queensland does not report residential beds, but has a high number of non-acute beds, some of which other states may classify as residential.

Tasmania does not classify any of its services as public psychiatric hospitals and does not classify any of its extended treatment beds as non-acute, instead classifying them as residential. This impacts on the number of beds per 100,000 (table 8.3) which shows Tasmania at 18.8 compared to the national average of 29.2.

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[16] Hospital includes Public Psychiatric Hospitals and Specialised psychiatric units or wards in public acute hospitals.

[17] Residential includes government operated and partially or wholly funded government funded non-government organisation residential mental health services.

[18] Grants to non-government organisations excludes funding of non-government operated residential mental health services

Table 8.3: Public sector specialised mental health hospital beds per 100,000 population by hospital and program type, 2014-15

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public psychiatric hospitals	Acute	3.8	1.6	0.0	5.3	3.9	0.0	0.0	0.0	2.5
Public psychiatric hospitals	Non-acute	7.3	1.0	6.3	3.5	8.0	0.0	0.0	0.0	4.8
Public psychiatric hospitals	*Subtotal* [c]	11.1	2.5	6.3	8.8	11.9	0.0	0.0	0.0	7.3
Specialised psych. units / wards	Acute	19.2	17.5	16.2	18.4	16.9	18.8	18.1	16.9	17.9
Specialised psych. units / wards	Non-acute	5.8	2.3	7.1	1.6	0.0	0.0	0.0	0.0	4.0
Specialised psych. units / wards	*Subtotal* [c]	25.0	19.8	23.4	20.0	16.9	18.8	18.1	16.9	21.9
All specialised MH Beds	Acute	23.0	19.1	16.2	23.7	20.7	18.8	18.1	16.9	20.4
All specialised MH Beds	Non-acute	13.1	3.2	13.5	5.1	8.0	0.0	0.0	0.0	8.8
Total		**36.1**	**22.4**	**29.7**	**28.8**	**28.8**	**18.8**	**18.1**	**16.9**	**29.2**

Beds can also be classified by target population. For the general (adults aged 18 to 64) population, Tasmania is comparable with the national average. There is a gap in child and adolescent reporting as Tasmania did not have any dedicated beds for 0 to 17 year olds under the control of Mental Health Services. Patients in the 0 to17 age range needing admission are usually accommodated in paediatric wards with support from mental health clinicians. In 2014-15 there was 1 689 bed days across the State for this age cohort, which equates to 4.62 beds (1689/365). Given an estimated population in this age range of 118 191 gives a bed per 100 000 population of 3.92.

However, the situation for those aged 0-17 is changing. The 2017-18 State Budget included funding to upgrade the 4K children's ward at the Launceston General Hospital. The upgrade will incorporate specialist facilities for child and adolescent mental health patients. In addition, as part of the RHH redevelopment, mental health services will be accommodated on levels 2 and 3 of the new K-Block building.

There are a number of beds at the Roy Fagan Centre (psychogeriatric) that could be reported in the older person bed numbers for acute and non-acute, but as the whole facility is reported as residential those beds are not reported here as a specialised mental health hospital beds to avoid double counting.

Admitted patient care with specialised psychiatric care

People with mental illness may require admission to hospital. In hospital, patients can receive specialised psychiatric care in a psychiatric hospital or in a psychiatric unit within a hospital. Tasmania does not have any services classified as psychiatric hospitals. It has four services classified as psychiatric units in public acute hospitals; Department of Psychiatry (DoP) at RHH, Northside Clinic at LGH, Spencer Clinic at NWRH and the Wilfred Lopes Centre (Forensic).

In 2014-15, there were 157 104 mental health-related separations with specialised psychiatric care nationwide; equivalent to a national rate of 6.8 per 1 000 population. This is an increase over 2011-12 where there was 141 898 separations at a rate of 6.3 per 1 000 population.

Residential mental health care

Residential mental health care services are classified as services that provide specialised mental health care on an overnight basis in a domestic-like environment. Residential mental health services may include rehabilitation, treatment or extended care.

In Tasmania, residential mental health care services are provided through government operated facilities and government funded community sector organisations (table 8.4).

Table 8.4: Residential mental health care beds Tasmania

Beds located in mental health inpatient units outside of the hospitals:	**Location**	**No. of beds**
Mistral Place (Hobart)	South	10
Millbrook Rise Centre (New Norfolk)	South	27
Roy Fagan Centre (Lenah Valley)	South	42[19]
Tolosa Street (Glenorchy)	South	12
Sub Total:		*91*
Beds located in community sector organisations funded by the state	**Location**	**No. of beds**
Richmond Fellowship of Tasmania - Rokeby	South	14
Richmond Fellowship of Tas – Glenorchy	South	16
Richmond Fellowship of Tas – Moonah	South	6
Caroline House – Hobart	South	6
Langford Support Services	South	13
Richmond Fellowship of Tas – Mowbray	North	8
Anglicare Tasmania – Rocherlea	North	15
Richmond Fellowship of Tas – Ulverstone	North West	12
Anglicare Tasmania – Curraghmore	North West	12
Sub Total:		*102*
Grand Total:		**193**

[19] Previously 32 but advice from THS moved to 42 beds from 5 June 2017.

Nationally there were 7 749 continuing and completed episodes of residential care in 2014-15, with 301 701 residential care days provided to an estimated 5 819 residents. This equates to an average of 1.3 episodes of care per resident and 39 residential care days per episode.

Tasmania reported the highest rate of episodes of care at 21.3 per 10 000 population and the highest rate of residents at 11.9 per 10 000 population in 2014–15. This compares to national averages of 3.3 episodes of care per 10 000 population and 2.5 residents per 10 000 population (Figure RMHC.1). This high rate for Tasmania reflects the current service system and also how facilities are classified. As above, there are beds in some units that could be described as belonging in the non-acute specialised mental health beds, however due to the definition currently in use all beds are classified according to the facility profile and not the individual patient profile.

Nationally, the rate of residential care days was 129.8 per 10 000 population in 2014–15, with Tasmania reporting the highest rate (1 008.3) and Western Australia reporting the lowest (12.1).

Reform of Tasmania's mental health system

Rethink Mental Health Plan 2015-25

The Tasmanian Government has developed a long-term plan for mental health in Tasmania – the *Rethink Mental Health Plan 2015-25* (Rethink). Rethink is a plan for mental health in Tasmania that brings together promotion of positive mental health, prevention of mental ill-health and care and supports for people with mental illness into one strategic framework. It sets a reform agenda to improve the mental health and wellbeing of Tasmanians by identifying our vision, the principles that underpin our vision, our reform directions and our priorities for action.

Rethink outlines ten key directions for reform:

1. Empowering Tasmanians to maximise their mental health and wellbeing.
2. A greater emphasis on promotion of positive mental health, prevention of mental health problems and early intervention.
3. Reducing stigma.
4. An integrated Tasmanian mental health system.
5. Shifting the focus of the Tasmanian mental health system from hospital based care to support in the community.
6. Getting in early and improving timely access to support (early in life, early in illness)
7. Responding to the needs of specific population groups.
8. Improving quality and safety.
9. Supporting and developing our workforce.

10. Monitoring and evaluating our action to improve mental health and wellbeing.

Reform in community and primary settings

The current mental health service system in Tasmania relies heavily on public mental health services and in particular inpatient services. There continues to be significant demand for these services which can make immediate access difficult. Greater access to community support is the key to reducing the level of demand on these services and to positively influencing the recovery of people with mental illness.[20]

Community support is an important part of contemporary mental health service delivery, providing support for consumers to live successfully in the community, enabling consumers to maintain contact with family and friends, improving recovery, and supporting families and carers in their caring roles. Primary health is also important in shifting the focus to mental health support in the community.

There is evidence that long-term supported accommodation is an effective alternative to hospital-based care.[21] Evaluations of supported accommodation programs have shown success in reducing the frequency and duration of hospital admissions and ED attendances, reducing the incidence of involuntary treatment, maintaining or improving symptoms and psychosocial functioning, maintaining housing and reducing the overall cost of mental health care.[22]

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[20] The review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland August 2014.

[21] Chopra P, Harvey CH, H. Continuing accommodation and support needs of long-term patients with severe mental illness in the era of community care. Curr Psychiatry Rev. 2011; 7: 67-83 (as reported in the review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland August 2014).

[22] Meehan T, Madson K, Shepherd N, Siskind D. Final evaluation report of the Queensland Government's Housing & Support Program. Brisbane: Department of Psychiatry (UQ) and Service Evaluation & Research Unit, The Park Centre for Mental Health; 2010; Bruce J, McDermott S, Ramia I, Bullen J, Fisher KR. Evaluation of the Housing and Accommodation Support Initiative (HASI): Final Report. Sydney: Social Policy Research Centre, University of New South Wales; 2012; Health Outcomes International. SA Health: Evaluation of the Housing and Accommodation Support Partnership Program - Final Report. Adelaide: Health Outcomes International; 2013 (as reported in the review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland, August 2014).

Other models of community support have also been shown to be effective in reducing the severity of mental illness. These include personalised support services (such as packages of care and recovery programs) and group support services (such as clubhouse and GROW models) which have the potential to improve consumer empowerment and quality of life;[23] and mutual support and self-help groups which have been found to improve social participation and symptom management.[24] Group and mutual support services for families and carers have a good evidence base for improving understanding of mental illness, social networks, and coping skills.[25]

This is why shifting the focus from hospital based care to support in the community and working to better integrate the Tasmanian mental health system are key reform directions for the Tasmanian Government. To deliver on these reform directions, the Tasmanian Government further invested in community support through new funding in the 2017-18 State Budget, which will be used for important community sector services including:

- $11.4 million for packages of care to support people with mental illness;
- $1.7 million to Rural Alive and Well (RAW) for mental health outreach services in rural Tasmania;
- $1.8 million for the Suicide Prevention Early Intervention Referral Service supporting people who have attempted suicide to get the help they need; and
- $525 000 to continue grassroots mental health support through Neighbourhood Houses and increased advocacy support for people with mental illness.

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[23] The review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland, August 2014.

[24] Cook JA, Copeland ME, Corey L, Buffington E, Jonikas JA, Curtis LC, et al. Developing the evidence base for peer-led services: Changes among participants following Wellness Recovery Action Planning (WRAP) education in two statewide initiatives. Psychiatric Rehabil J. 2010; 34(2): 113-20.

Corrigan PW. Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. Psychiatry Serv. 2006; 57(10): 1493-6.

Stant AD, Castelein S, Bruggeman R, Busschbach JT, Gaag M, Knegtering H, et al. Economic Aspects of Peer Support Groups for Psychosis. Community Mental Health J. 2011; 47(1): 99-105 (as reported in The review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland, August 2014.

[25] Munn-Giddings C, McVicar A. Self-Help groups as mutual support: What do carers value? Health Soc Care Community. 2007; 15(1): 26-34 (as reported in the review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland August 2014).

In addition, funding has been provided to establish a peer workforce in public mental health services. Peer workers will commence with community mental health teams and be employed in the THS during 2017, starting with the North and North-West of the State.

Nationally and internationally, peer workforce is a growing component of the mental health workforce. There is increasing evidence of the benefits of embedding the lived experience in the mental health service system to improve the recovery-focus of services. It has been reported that the widespread introduction of people with lived experience of mental health problems into the mental health workforce is probably the single most important factor contributing to changes towards more recovery-oriented services[26].

The Tasmanian Government is also supporting primary health to be the 'front end' of mental health care in Tasmania through education and training and consultation liaison models. Additional funding was allocated in the 2016-17 State Budget to support implementation of consultation liaison models.

Additional joint action between the Tasmanian and Australian Governments to integrate the mental health service system in Tasmania will be guided by the Fifth National Mental Health and Suicide Prevention, which was endorsed by the Council of Australian Governments Health Council on 4 August 2017.

Reform in bed based settings

Regardless of how well we provide community supports, there will always be instances where consumers will need to receive specialised psychiatric care in an inpatient setting. Adult inpatient mental health services at our three major hospitals are supported by subacute units at Mistral Place, Millbrook Rise Centre, Roy Fagan Centre and Tolosa Street.

[26] Repper, J. et al, (2013) Peer Support Workers: a practical guide to implementation (Implementing Recovery through Organisational Change (ImROC) Briefing), Centre for Mental Health and Mental Health Network, NHS Confederation.

Sub-acute settings provide an alternative to hospital admission and/or a stepped care approach to mental health care and support.[27] These services can provide a 'step-up' for consumers in the community needing an increased level of support with the aim of preventing an inpatient admission, or a 'step-down' or transitional arrangement for people whose illness has stabilised enough to be discharged from inpatient care but who still require support to develop living skills and community connections or to find housing.[28] Sub-acute services can be delivered through a partnership model between clinical mental health services and non-clinical service providers, allowing consumers to receive both clinical treatment and psychosocial support in the one setting.[29]

Based on analysis of available data, there has also been a continuing increase in both the demand for service and client complexity over this time.

This is reflected in a number of ways including:

- an increase in the occurrence of bed-block both within the RHH and across the broader system;
- a growing number of clients in all units with extended lengths of stay; and
- a recent significant increase in the number of presentations of clients who are homeless.

These issues have been compounded by a number of other operational factors that have impacted on patient flow between services, particularly after hours.

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[27] Thomas KA, Rickwood D. Clinical and cost-effectiveness of acute and subacute residential mental health services: A systematic review. Psychiatry Serv. 2013; published online 1 August 2013 (as reported in the review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland August 2014).

[28] The review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland, August 2014.

[29] The review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland, August 2014.

A number of strategies to improve patient flow across the statewide mental health service system have been identified by Statewide Mental Health Services within the THS and are outlined in the June 2017 report *Mental Health Services: A Plan to Deliver Improved Patient Flow*. Nine short term strategies, eight medium term and one long term strategy have been identified. They encompass actions such as improving communication and client transfers between inpatient services, amending admissions policies, reconfiguring services to ensure more step-up and step-down beds are available at subacute facilities and increasing the capacity for respite. It is expected that establishment of consultation liaison models will also act to alleviate demand on inpatient services. In line with Rethink, models of care will also be reviewed with the aim of further increasing community support and reducing reliance on hospital based mental health services.

Inpatient services at the RHH will also continue to be supported by the Psychiatric Emergency Nurse (PEN) Service. The PEN Service was established to improve patient outcomes and reduce pressure on the RHH ED. Through the PEN Service patients presenting at the RHH ED with mental conditions are able to receive assessment and treatment by a nurse with training specific to the field of mental health and high level knowledge of potential discharge options and available community supports. This service was established in July 2010 with funding by the Australian Government. Following expiry of this funding in June 2013 the Tasmanian Government has taken on the funding responsibility for this valuable service.

In response to recent pressure on the ED from increased numbers of mental health presentations, a Mental Health Observation Unit is currently being progressed as part of the ED of the Royal Hobart Hospital. The Observation Unit will cater for up to five people with a mental health issue who present to the ED and will be delivered by end of October 2017.

The key objectives of the Mental Health Observation Unit will be to:

- improve consumer outcomes by providing rapid streaming to acute specialised psychiatric assessment, observation and treatment;
- reduce mental health re-presentations to the ED;
- reduce the length of stay within the ED for consumers with mental health issues;
- reduce admission rates of mental health consumers to acute inpatient mental health beds;
- reduce the length of stay of mental health consumers to acute inpatient mental health beds;
- improve linkages with community based mental health support and other services as required;
- increase the capacity of clinicians in crisis assessment and risk assessment to promote skills development and training in a supervised setting; and
- provide a specialist consultation liaison service to the ED of the Royal Hobart Hospital.

Mental health facilities at the RHH

Planning for the number of acute mental health beds in the RHH has been influenced by recent reforms in the provision of mental health services in Tasmania and nationally, which has seen a shift in emphasis to community based care. The provision of acute mental health beds at the RHH has also been impacted by the RHH redevelopment process.

Between 2013 and 2014 the number of mental health beds at the RHH reduced from 42 to 38. Throughout 2014, beds for patients needing less intense support were underutilised. The then Tasmanian Health Organisation (THO) South anticipated the trend of below capacity occupancy would continue due to the increasing focus on providing mental health treatment in the community and recommended closing further beds. By mid-2015, there were 33 mental health beds at the RHH.

Mental Health Services at the RHH were relocated from B-Block into the Temporary Inpatient Facility in November 2016 . They will move into Level 2 and Level 3 of K-Block after the new inpatient facility is completed in 2019. The Temporary Inpatient Facility (J-Block) has capacity for 33 beds. K-Block is designed to have 33 mental health inpatient beds. Significant work has been done to improve the design and amenity for mental health inpatients in K-Block and in the Temporary Inpatient Facility. In 2014, the RHH Redevelopment Rescue Taskforce (the Taskforce) oversaw the development of a decanting plan to relocate hospital services, including mental health, from B-Block prior to its demolition.

The work of the Taskforce involved broad consultation including input from THO-South clinicians and commissioned expert advice and was supported by a Professional Reference Group of stakeholders with an interest in the project. Throughout the design process consultation also occurred with staff, mental health stakeholders including consumer and carers groups and relevant professional groups and unions (notably the Australian Medical Association and the Australian Nursing and Midwifery Federation, both represented on the Professional Reference Group).

The decanting plan was assessed as being feasible and containing minimal clinical risk to patients. Compared to B-Block, the Temporary Inpatient Facility provides more privacy for patients, being configured to predominantly provide single-bed rooms. New spaces include a sensory modulation room and a de-escalation room available in the high dependency unit. There has recently been an increase in the demand for mental health services and client complexity in inpatient facilities which has impacted on the RHH. As noted above, the THS is currently implementing a number of strategies to alleviate the resulting bed block.

Mental Health Services - Conclusion

The Tasmanian Government is committed to meeting the challenges currently being experienced in the mental health system in Tasmania, including increased demand for inpatient services. It is implementing strategies to improve the ability of our inpatient services to meet current demand while also continuing to invest strongly in support services in community and primary settings.

The Tasmanian Government recognises that people living with mental illness may access health care, social care, housing and other services. If the needs of consumers and carers are truly at the centre of the way in which services are planned and delivered, there needs to be greater integration between mental health services and other services and better recognition of the broader factors impacting of mental health and issues that affect people living with mental illness. This means connecting health and areas such as disability, housing, education and employment. It also means extending integration into prevention and early intervention.

The Tasmanian Government is implementing a number of reforms that complement and will be considered as part of Rethink, including *Tasmania's Affordable Housing Strategy 2015-25*, the Joined Up Human Services project, *Safe Homes, Safe Families: Tasmania's Family Violence Action Plan 2015-20*, and *Strong Families, Safe Kids*. In addition, an Alcohol and Other Drugs Service System Framework is due to be developed in the second half of 2017 and the Tasmanian Government is continuing to support the implementation of the National Disability Insurance Scheme.

9 Conclusion

Since the Tasmanian Government came to office in 2014, results in several key areas of the health portfolio have improved significantly, such as elective surgery, which has seen greatly improved outcomes for waiting lists, particularly for the longest waiting patients. However, as highlighted by numerous reports, most recently by the Commission on Delivery of Health Services in Tasmania, there are entrenched issues which must be addressed in order for Tasmania to have a sustainable health system into the future.

Many of the issues faced by the Tasmanian health system are common across Australia and indeed the developed world. Chief among these are challenges associated with increasing consumer expectations regarding access to health care. Changing these expectations will require long term consumer engagement to emphasise the importance of individuals taking greater personal responsibility for their well-being and having a greater emphasis on preventative care.

The increasing number of patients presenting with multiple morbidities is also putting pressure on the acute health system in terms of both cost and management of patients who are concurrently on multiple treatment pathways.

A further problem is patients entering the acute hospital system despite this not being the most appropriate location for their treatment. This problem is due in part to an absence of alternatives to hospital beds. Such alternatives may include Hospital in the Home and Rehabilitation in the Home type programs.

In our Federal system of Government, the Australian Government plays a significant role in effecting demand for acute health services. Recent Australian Government policies such as tying health funding to activity, defunding preventative health programs and freezing the Medicare rebate have contributed to increased demand for acute services. The Tasmanian Government will use fora such as COAG to influence Australian Government policy in these areas.

While there are several factors influencing demand for acute health services over which the Tasmanian Government has little direct control, there are many areas where the Government has a role to play in leading reform. These include reforms in the area of role delineation, workforce, demand management, models of care and patient flow management.

The challenge facing the Government is to balance the immediate need of acute care patients with the need to implement long term reform of the health system. As highlighted in this submission, the Government is working to address both of these needs without causing detriment to the other. The reforms commenced under One Health System will result in more Tasmanians receiving access to better care as efficiencies are introduced by adopting a Statewide approach with the patient at the centre of all decisions. At the same time, the Government has increased health funding by record amounts, which has resulted in improvements in several key measures, in particular those relating to elective surgery.

The Government will continue to work to improve health outcomes for Tasmanians. The recently released "Building Your Future" policy document includes the following targets:

- 90 per cent of Tasmanians will be treated within clinically-recommended timeframes for their elective surgery by the end of the next four year term of Government;
- 90 per cent of emergency presentations will be in and out of the ED within four hours by 2022;
- a 20 per cent reduction in the suicide rate by 2022; and
- to reduce emergency ambulance response times to national average waiting time by 2025.

Meeting the elective surgery and ED targets will be supported by opening more beds and recruiting more health professionals, backed by the $7 billion health budget. Having access to the best health services available is a key driver behind the $689 million Royal Hobart Hospital Redevelopment, which once complete will provide capacity for an additional 250 beds. These financial investments will be complemented by ongoing reforms to improve the efficiency, safety and quality of acute health service delivery in Tasmania.

10 Appendices

Appendix 1: Definition of Acute Health Services

The Australian Institute of Health and Welfare (AIHW) defines acute hospitals as "Public and private hospitals that provide services mainly to admitted patients with acute or temporary ailments. The average length of stay is relatively short." (AIHW, 2017).

The AIHW defines admitted patient care as consisting of the following categories (AIHW, 2017):

- Acute care;
- Rehabilitation care;
- Palliative care;
- Geriatric evaluation and management;
- Psychogeriatric care;
- Maintenance care;
- Newborn care; and
- *Other admitted patient care* (this is where the principal clinical intent does not meet the criteria for any of the above).

The Independent Hospital Pricing Authority (IHPA), which is responsible for managing the national classifications of different types of health care activity to facilitate the operation of national Activity Based Funding and the National Hospitals Cost Data Collection, currently uses six different patient service categories:

- Admitted acute care;
- Subacute and non-acute care;
- Non-admitted care;
- Mental health care;
- Emergency care; and
- Teaching, training and research.

Appendix 2: Extract from the Commission on Delivery of Health Services.

The full version of the report is available at:

https://stors.tas.gov.au/store/exlibris3/storage/2014/05/09/file_3/1240287.pdf

"The Tasmanian Context" (pages 86-87)

The Tasmanian health system has long been a subject of concern, both in terms of excessive costs and inadequate delivery of health services. It has been reviewed, reported upon and debated. Mixed responses to implementation of these various reform processes have polarised organisational culture in the Tasmanian health system. While there are many individuals whose enthusiasm and willingness to embrace change has been spurred by the understanding that there are still significant opportunities for improvement, and who remain strongly committed to achieving system improvements, others are experiencing reform fatigue.

We have observed a deeply engrained culture of resistance to change, evidenced by the system's inertia in the face of several reviews recommending reform. There is also intra-system discord within both administrative and clinical elements of the health system, as well as a level of defensiveness in response to either explicit or implicit criticism of current practices. This culture of resistance, although not universal, includes varying degrees of denial about problems with the health system; or, in other cases, a resigned cynicism about the ability of health system leaders to act successfully on initiatives to increase efficiency and sustainability.

The influence of local political interests on health system decisions has been a consistent source of frustration. Reforms, particularly with regard to overarching issues of governance, cannot be enacted where opportunistic political interference can intrude into the reform process. Health care is a political issue, but political concerns must not interfere with the implementation of reforms once those reforms have been accepted at a governmental level. There can be no effective governance, and therefore no genuine and sustainable reform, if clinicians or administrators believe that they can circumvent or redirect reform by making use of political connections and short-term political tactics. Such tactics are the product of a culture in which too many decisions are made on the basis of what is politically convenient, and one where self-interest is placed before the interests of patients.

Against this environment, there are a number of longstanding cultural attitudes and behaviours that remain unaddressed, and are undermining the realisation of a functional governance system in Tasmania. We have observed a lack of respect amongst key stakeholders, competition and a lack of cooperation, and resistance to routine performance measures. While there are capable and committed individuals within the health system, there are administrators and clinicians in leadership positions who behave in an unduly territorial manner. Personal animosities appear to override professional considerations and what should be universally accepted codes of conduct.

The move to three Tasmanian Health Organisations (THOs) appears to have acted, in effect, to further legitimise dangerous and undisciplined behaviour within the system, particularly with regard to collaborative practice and collaboration. A measure of scrutiny provided by the daily realities of working within a statewide system has been lost, and some poor work practices have been shielded within the THOs. Those who do have the authority to address and eliminate poor behaviour, the THO Governing Councils, do not appear to exercise it.

Throughout our stakeholder consultations, we heard many reports of disillusionment based upon immediate, first-hand observation of poor behaviour that has gone unchecked. Every system, every jurisdiction will encounter individual instances of misdeeds and inappropriate actions and relationships. Tasmania lacks the mechanisms to ensure that the consequences of such behaviour are swift and widely understood, and thereby creates a culture where behaviour that falls far outside acceptable professional conduct is tolerated, and able to thrive.

The absence of clear accountability mechanisms and lack of strong leadership to enforce them have fostered an environment where there are few, if any, sanctions for unacceptable behaviour. This is not lost on those working within the system, with direct and indirect calls from respondents to our governance survey for improved accountability within Tasmania's health system.

There are several problems of leadership at all levels of Tasmania's health system that must be addressed if the necessary improvements are to be realised. The ability and willingness to stridently defend one's own institution and interests does not constitute leadership, and in Tasmania, it appears such combativeness is confused with strong leadership. A well-led health system is one characterised by mutual respect, a willingness to listen and a shared common purpose. Tasmania's health system leaders need to cooperate in forging this common path, with a leadership culture that is collaborative, inclusive and united around the aim of improving patient outcomes.

Appendix 3: Data

Chart 1: Total separations (episodes of admitted patient care) Tasmanian Public Hospitals 2011-12 to 2015-16

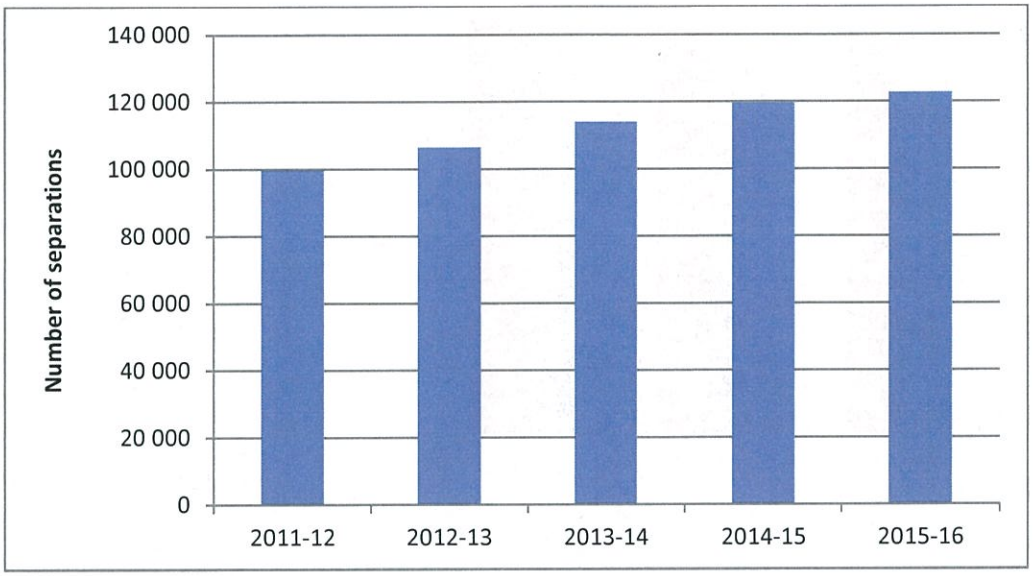


Table 1: Total separations (episodes of admitted patient care) Tasmanian Public Hospitals 2011-12 to 2015-16

	2011-12	2012-13	2013-14	2014-15	2015-16
Total separations	99 632	106 358	114 033	119 506	122 604

Source: AIHW (2017) Admitted patient care 2015-16: Australian hospital statistics; AIHW (2016) Admitted patient care 2014-15: Australian hospital statistics; AIHW (2015) Admitted patient care 2013-14: Australian hospital statistics.

Chart 2: Number of overnight and same-day admitted patients 2013-14 to 2015-16

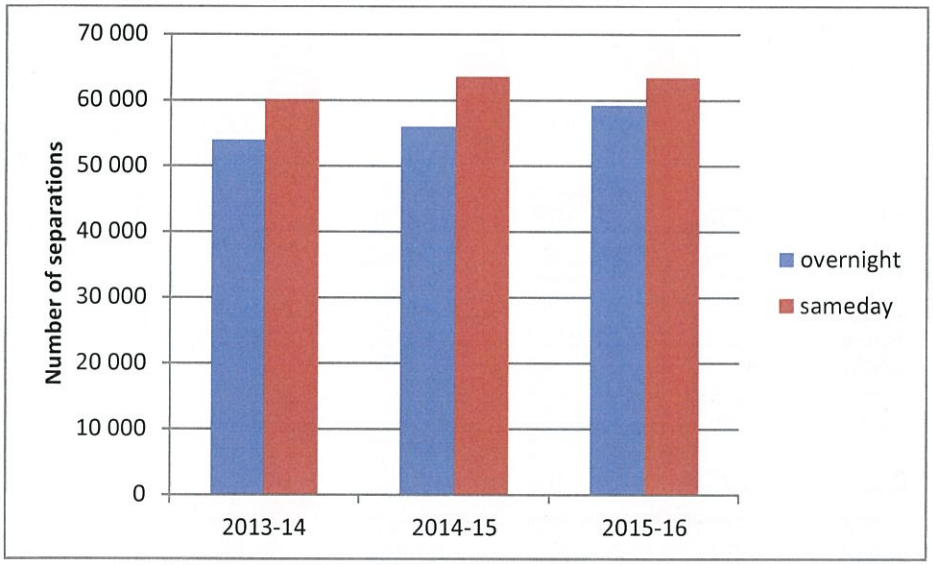


Table 2: Number of overnight and same-day separations 2013-14 to 2015-16

	2013-14	2014-15	2015-16
Overnight separations	53 974	55 946	59 167
Same-day separations	60 059	63 560	63 437
Total separations	114 033	119 506	122 604

Chart 3: Tasmanian public hospital overnight and same-day separations per 1 000 population

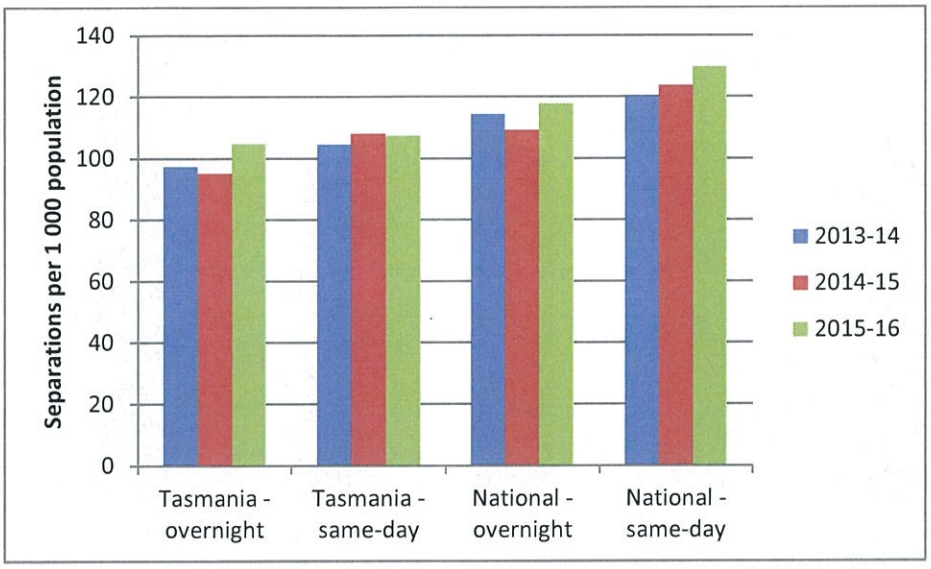


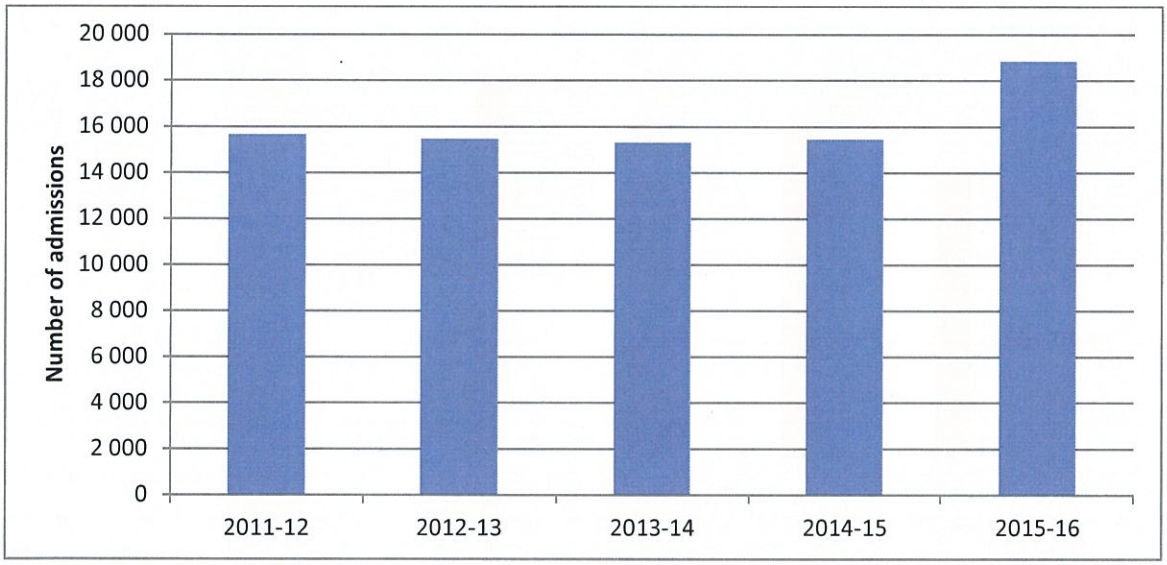
Table 3: Tasmanian public hospital overnight and same-day separations per 1 000 population

	2013-14	2014-15	2015-16
Tasmania - overnight	97.4	95.2	104.7
Tasmania - same-day	104.5	108.1	107.3
National - overnight	114.3	109.2	117.8
National - same-day	120.1	123.7	129.7

Note: Comparable data for public hospital overnight and same-day separations per 1 000 population for 2011-12 and 2012-13 are not available.

Source: AIHW (2017) Admitted patient care 2015-16: Australian hospital statistics; AIHW (2016) Admitted patient care 2014-15: Australian hospital statistics; AIHW (2015) Admitted patient care 2013-14: Australian hospital statistics

Chart 4: Number of admissions from elective surgery waiting list 2011-12 to 2015-16



Note: emergency admissions from the elective surgery waiting list have been excluded.

Table 4: Number of admissions from elective surgery waiting list 2011-12 to 2015-16

	2011-12	2012-13	2013-14	2014-15	2015-16
Admissions from elective surgery waiting list	15 802	15 369	15 198	15 598	18 973

Source: AIHW (2017) Elective surgery waiting times 2015-16: Australian hospital statistics

Chart 5: Additions to and removals from waiting lists for elective surgery 2011-12 to 2015-16

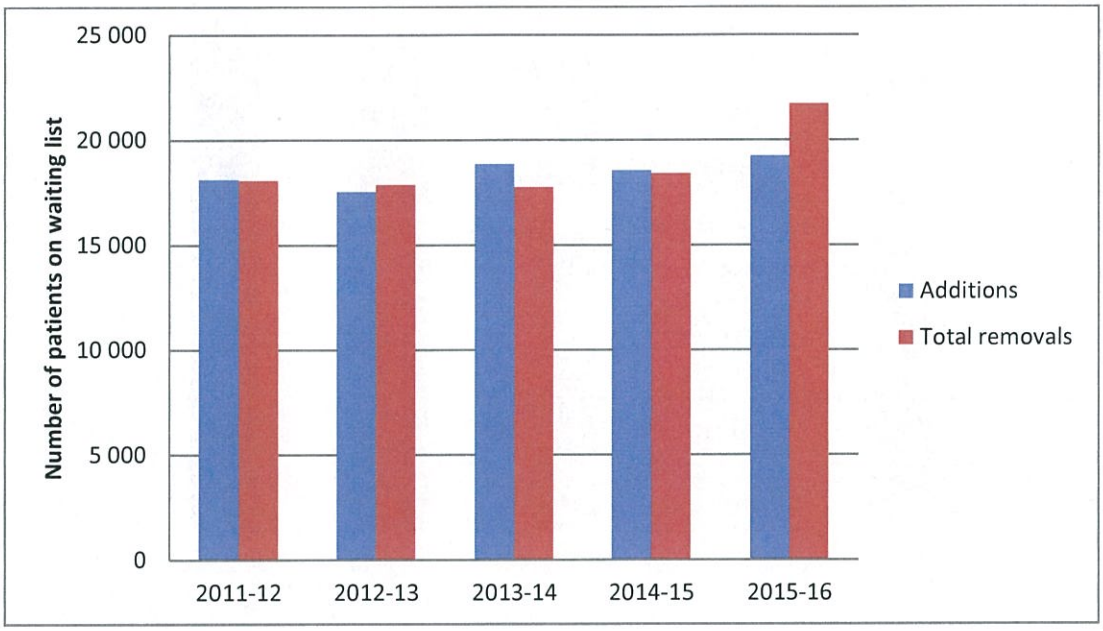


Table 5: Additions to and removals from waiting lists for elective surgery 2011-12 to 2015-16

	2011-12	2012-13	2013-14	2014-15	2015-16
Additions	18 114	17 532	18 849	18 538	19 224
Removals					
Elective admission	15 674	15 475	15 315	15 460	18 842
Emergency admission	128	106	117	138	131
Total admissions	15 802	15 369	15 198	15 598	18 973
Not contactable/died	309	394	488	470	369
Treated elsewhere	383	448	459	519	450
Surgery not required or declined	1 104	1 009	927	1 115	1 284
Transferred to another hospital's waiting list	105	95	77	198	107
Not reported	370	444	480	515	547
Total removals	18 073	17 865	17 746	18 415	21 730

Sources: AIHW (2017) Elective surgery waiting times 2015-16: Australian hospital statistics; AIHW (2016) Elective surgery waiting times 2014-15: Australian hospital statistics; AIHW (2015) Elective surgery waiting times 2013-14: Australian hospital statistics; AIHW (2014) Australian hospital statistics: Elective surgery waiting times 2012-13; AIHW (2013) Australian hospital statistics: Elective surgery waiting times 2011-12.

Chart 6: ED presentations 2011-12 to 2015-16

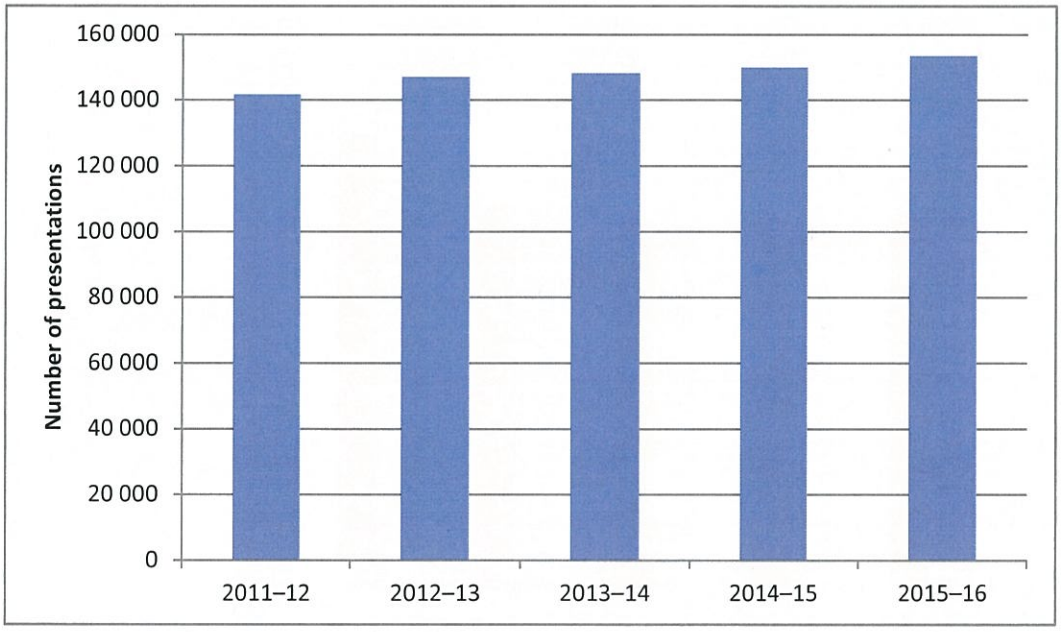


Table 6: ED presentations 2011-12 to 2015-16

	2011-12	2012-13	2013-14	2014-15	2015-16
ED presentations	141 700	147 064	148 278	150 076	153 541

Source: AIHW (2017) ED care 2015-16: Australian hospital statistics.

Chart 7: Tasmanian public hospital ED presentations - waiting times 2011-12 to 2015-16

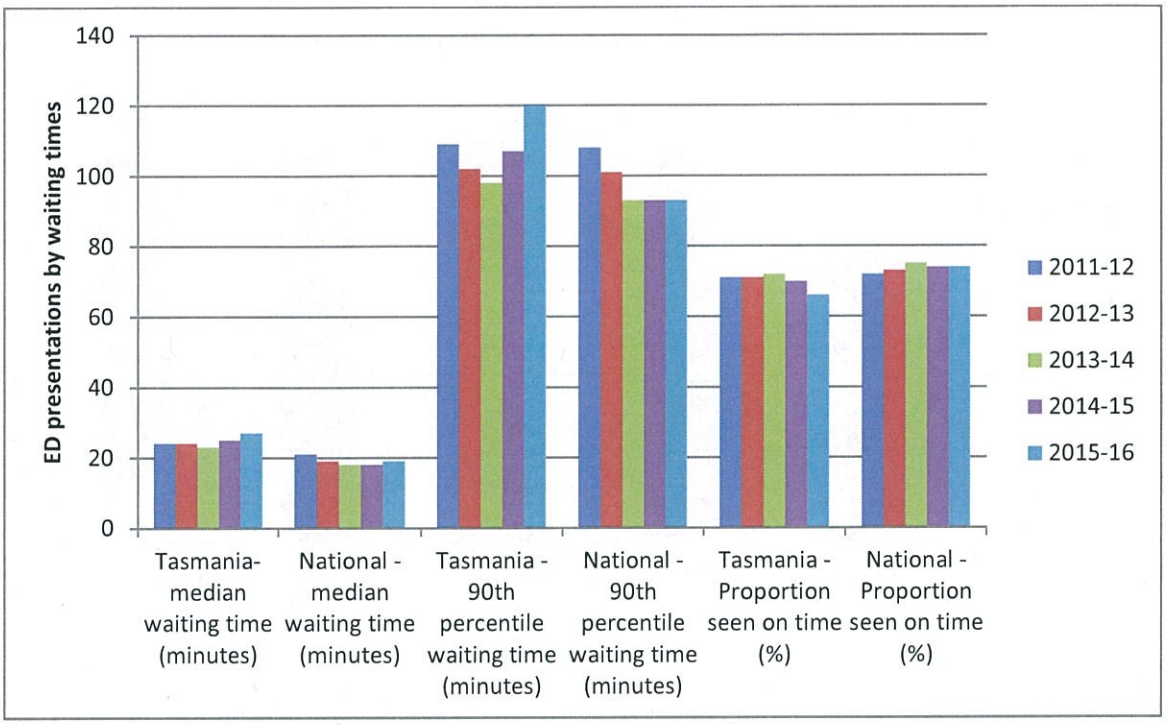


Table 7: Tasmanian public hospitals ED presentations - waiting times 2011-12 to 2015-16

	2011-12	2012-13	2013-14	2014-15	2015-16
Tasmania – median waiting time (minutes)	24	24	23	25	27
National – median waiting time (minutes)	21	19	18	18	19
Tasmania – 90th percentile waiting time (minutes)	109	102	98	107	120
National – 90th percentile waiting time (minutes)	108	101	93	93	93
Tasmania – Proportion seen on time (%)	71	71	72	70	66
National – Proportion seen on time (%)	72	73	75	74	74

Source: AIHW (2017) ED care 2015-16: Australian hospital statistics.

Chart 8: Non-admitted patient service events in Tasmanian Public Hospitals 2011-2012 to 2015-2016

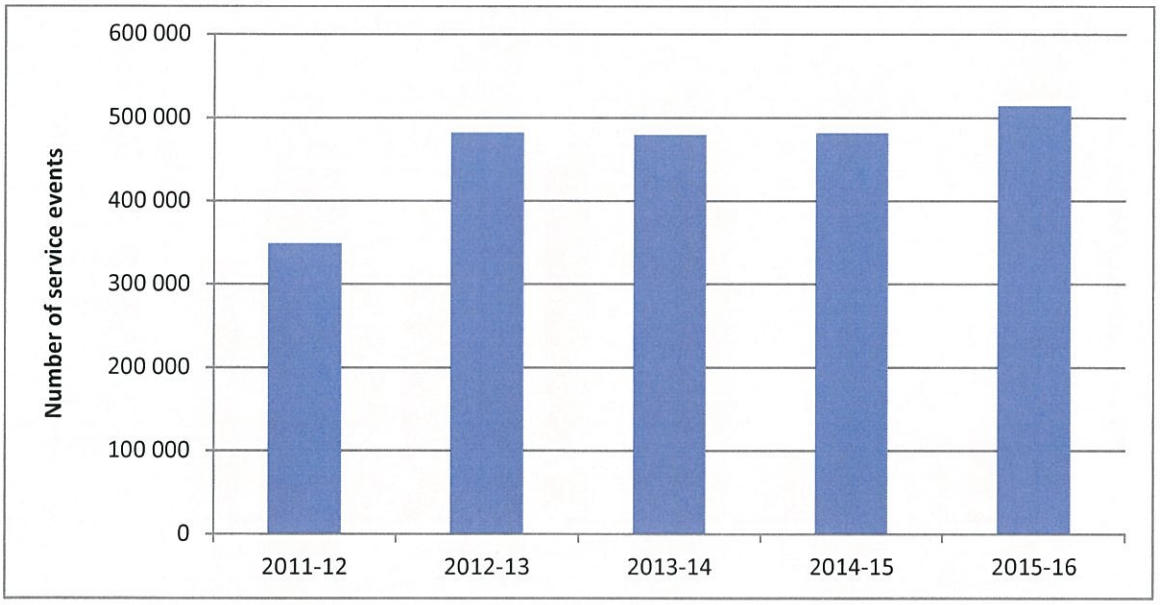


Table 8: Non-admitted patient service events in Tasmanian Public Hospitals 2011-2012 to 2015-2016

	2011-12	2012-13	2013-14	2014-15	2015-16
Total non-admitted patient service events	349 000	482 246	483 790	487 136	521 322

Source: AIHW (2017) Non-admitted patient care 2015-16: Australian hospital statistics; AIHW (2016) Non-admitted patient care 2014-15: Australian hospital statistics; AIHW (2015) Non-admitted patient care 2013-14: Australian hospital statistics.

Chart 9: Average available Tasmanian public hospital beds per 1 000 population

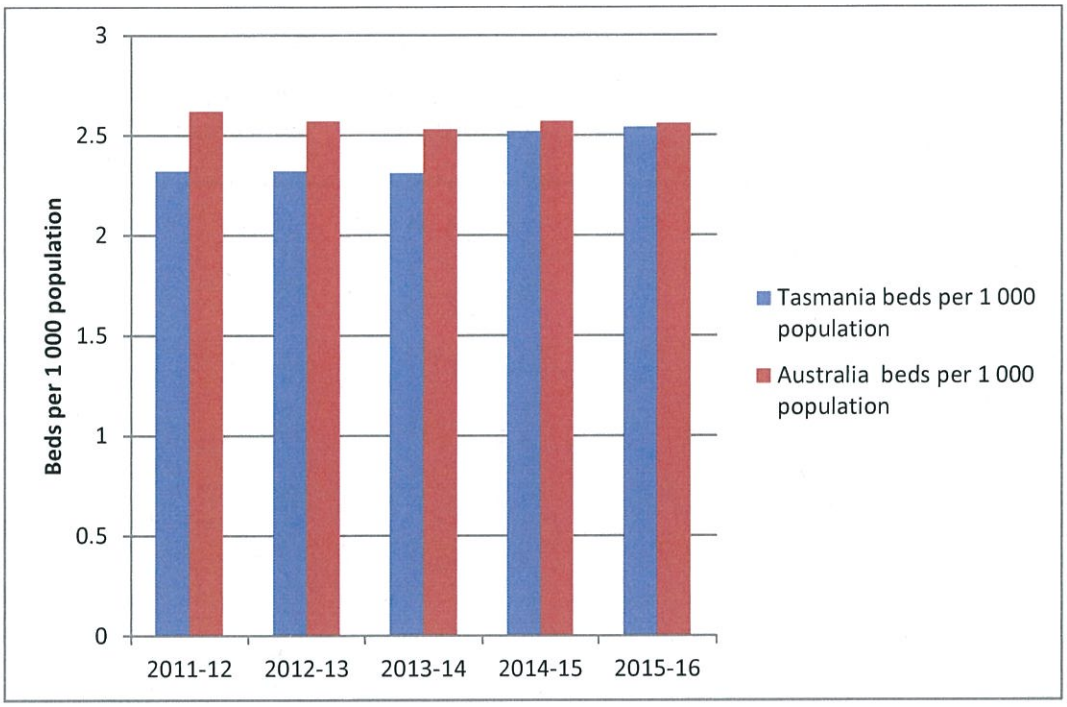


Table 9: Average available Tasmanian public hospital beds per 1 000 population

	2011-12	2012-13	2013-14	2014-15	2015-16
Tasmania	2.32	2.32	2.31	2.52	2.54
Australia	2.62	2.57	2.53	2.57	2.56

Source: AIHW (2017) Hospital resources 2015-16: Australian hospital statistics.

Table 10: Multimorbid vs non-multimorbid acute episodes in Tasmanian Major Hospitals in 2015

	<6 chronic conditions	6+ chronic conditions
Total Persons	50 608	3 904
Total Episodes	93 603	18 096
Total Episode days	238 512	61 100
Episodes Average Length of Stay (days)	2.5	3.4
Episodes per person per annum	1.8	4.6
Days per person	4.7	15.7
Hospital Acquired Complication rate per Episode	2.60%	5.00%
Hospital Acquired Complication rate per Person	4.80%	23.20%

Source: Department of Health and Human Services, internal analysis.

11 References

Specific references are noted as footnotes throughout the document. Other references used are as per below.

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Section 3

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